			Sta	ite of Maryland	-			Men	al Hygie	ene	7 *9	0.0	1701
÷			Registrar 1. Decedent's Name (First, Middle, Last)		Cen	ificate of l	Death	120	Reg ate of Death	j. No. 🚄 📗	J 1	3. Time	Of Death
	Physici		1	Proctor		(R		iva N	lonth,		Year	2	o7 _{4 M}
7	/Media		4a. Facility Name (If not institution, give street			4b. City, Town, or	Location of Dea		trch	4c. County o	f Death	4	
C	- Aumin		11781 Duley Sta	TON Rd		UPDER	MArl	bore	٥	Prince		2000	0
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hr Hours Min		ate of Birth Nonth, Day,		9. Birthp	lace (State	or Foreign
ls.	Director		579-28-7637	98	Yrs.	- Days	Tiodio IVIII	0.6	5/11/			ylan	d
	land Sw		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loca	ation					1	0d. Inside	City Limits
	Mary -f sho	현	Maryland Prince Ge	orges Upp	or M	arlboro						1 🐴 Y e	s 2 No
	r 28a	Director	10e. Street and Number	orges oppo	CI M	10f. Zip Code			100	g. Citizen of Wi	nat Coun	try?	_
	th wit 23a o ist be		11781 Duley Statio	on Road		2077	2			USA			
	r dea	Funeral	11. Marital Status 12. Wa	is Decedent Ever in U.S. med Forces?	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (In. Mexican. Pue	(Specify)	res or No-	14. Race			
36	or It	by Fu	1 Never Married 2 Married 1]Yes 2.X∐No ′es,Give	1	JYes 2X No	Specify:		,, 515.7				
2-0036	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed b	15. Decedent's Education	ar or Dates:	6a Decede	nt's Usual Occupa	ation		16	Specify: 6b. Kind of Bus			
15	nin 72 n "ng Medic	Completed	(Specify only highest grade comp		(Give ki	nd of work done of NOT use retired	during most of w	orking	"	D. Tana or Bas	111633/1110	lustry	
212	d with giene giene r tha	mo.	12		asonr	y Mecha	anic		F€	ederal	Go	vern	ment
D	be file Ital Hy od otho event	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (Firs	t, Middle, Ma	aiden Surname)		
Уa	should be filed and Mental Hygi marked other umatic event, the	2	Thomas Henry		octor		Fanni		M			octo	
Maryland	har har 7 is trau		19a. Informant's Name/Relationship (Type. Pri	nt) 1	19b. Mailing	Address (Street a	and Number or I	Rural Rou	ite Number, (City or Town, S Mar	tate Zip y I a	nd20	772
	s 1 and if Health item 27 other to	. 4	Thomas Proctor Sr.	/Son 1	11781	Dulev	Statio	on R	d.Upr	er Ma	rlbo	oro_	
altimore,	e = 5		1X Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	I from State	etery, crema	tory or other plac	e) ;						
<u>=</u>	구두루수		21. Signature of Puneral Service Licensee	Rest	ırrec	Name and Addres	s of Facility 7	15/2	00 / C	Clinto	n,_ [Mary.	Land
ñ	Departing Department on the once.		I Llind I	191	20	605 Aqı	asco I	aams Rd.	Aguas	co.Ma	ome rvl:	PA and '	20608
			23a. Part1. Enter the disease, or commidation shock, or heart failure. List only one cau		o not enter	the mode of dying	g, such as cardi	ac or resp	piratory arres	t,	7 1	Approxim Interval B	ate
7	Physician		Immediate Cause (Final disease or condition	Renal	FAIL							Onset and	d Death
, A	/Medical Examiner		resulting in death)	oue to (or as a consequence		6						MEEN	-3
	Exammer	_	Sequentially list conditions, b	Arterialchero	11	General	13e					yen.	ſ
	ted nsit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequenc	ce of):							,	
	be executed ician and burial-transit	Exar		ue to (or as a consequence	ce of):						-		
8/60	icate be executed physician and the burial-transit	dical											
٥	rtificate ng physi as the l	Nedi	IF FEMALE:								Ì		
X Q Q	tth ce tendir or use	an/I	23b Was decedent pregnant 23c. If y	es, outcome pf pregnancy]Live birth 2□ Fetal dea		ctopic pregnancy				23d. Date		-	.,
	the death certifi y the attending ched for use as	Physician/Me	1 Ves 2 No 4L	Pregnant at time of death Unknown		Other (specify)				Mont	ın	Day	Year
7.	that the		Part II. Other significant conditions contributing	ig to death but not resulting	n in the und	erlying cause give	en in Part I		3e Did toha	cco use contrib	ute to th	e cause o	f death?
ďS,	w requires that the death certifi been signed by the attending I should be detached for use as	d by	Hypertension	· · · · · · · · · · · · · · · · · · ·	y	on, nig eddoo givo	arri.	-	1 □ Yes				Unknown
Hecord	w req been shoul	lete							4a. Was an				
Ä	sician: The law certificate has b rector, page 2 s	Completed						. -	autopsy performe	ed?de	eath?		s available cause of
VITal		Be Co	25. Was case referred to medical				26. Place of De			1 1 1	Yes	2 No	
	Physician: this certificatal director,	To B	examiner? 1 ☐ Yes 2 ☐ No Hospita	1 ☐ Inpatient 2 ☐ ER/0	Outpatient	3 DOA Othe	r.			ce 6 □Other	(Specif	v)	
п ог	ng Pt fter th ineral		27. Manner of Death 1 ☑Natural 5 ☑Pending	Date of Injury 28t (Month, Day Year)	b. Time of Injury	28c. Injury Work				injury occurre			
<u> </u>	tendi eath. tor: A the fu	catio	2 Accident investigation			M 1□1	res 2 □ No						
JIVISION	or At after d Direc in by	Certification:	4 Homicide determined 28e	Place of injury - At home, building, etc. (Specify)	farm, stree	t, factory, office			ocation (Stre lity or Town,	et and Number State)	r or Rura	l Route Nu	ımber,
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.		29a. Certifier 1 Certifying Physician:	To the best of my knowled	ige, death o	occurred at the tim	e, date and place	ce, and d	ue to the cau	se(s) and mon	ner as c	ated	
	n 24 h	Medical	2 Medical Examiner: O	the basis of examination d manner stated.	and/or inve	stigation, in my or	oinion, death oc	curred at	the time, dat	e and place, a	nd due to	the cause	e(s)
	To th Within To th COMP	Me	29b. Signature and title of certifier) . (1)		29c. License	number		290	I. Date signed	(Month,	Day, Year)	
1			Fourell M (le	lin (15)		386	6			3/12/0)		
*	200		30. Name and address of person who complete	d cause of death (Item 23a	a) (Type, Pri	int)		ı i		1. 1.			
1	11)			2150 Pennsyl. 32 Aegistrar's Signature	Van.a	Ave. N.	W. L	Nash	Ing ton	DC		20	037
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 3 2007	Programme & Signature	Los	ill)							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene ? 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 12, 2007 **Physician** Grace Agnes Phillips 1:10 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Dove House CarrollHospice It Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) NOV 11, 1916 7. Age (In vrs. last birthday) 9. Birtholace (State or Foreign **Funeral** Min Months Days Hours 1 □ M 2 🔀 F 90 Maryland 219-28-7135 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itama 23s or 28s-f show other traumatic avant, the Mudical Exempler must be notified at Westminster Carroll 1 Yes 2 No Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21157 515 Tremont Drive apt 7 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working end Mental Hygiene. Etementary/Secondary (0-12) College (1-4or 5+) Eggnog Company Factory Worker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Deportment of Health end Menta Important: If Item 27 Is marked any Injury or other traumatic average. John Wittenberg Ida Halfpenny ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene G. Gienow, daughter 2510 Appaloosa Way, Finksburg, MD 21048 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Memorial 3/14/2007 Elkridge, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funerat Service Licensee M01191 91 Willis Street, Westminster, MD 21157 Jan 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** wee /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ettending physician and for use as the burial-transit Due to (or as a consequence ot): Box 68760, Physician/Medical IF FEMALE 23c. It yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No should t 3 Probably 4 Unknown Completed 24b. Were autopsy tindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed page After this certificete funeral director, pag 1 Yes Division of Vital 2 1 No 25. Was case reterred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hos ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pr within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2638 WIZ me and address of person who completed cause of death (Hem 23a) (Type, Print) omen (70/0/stein UD-Wasieston 10 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

David Charles Pr		I- For State	ryland / De	epartme			Hygiene		200	7 0950
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			- Dodin		2. Date of De	Reg. No.		3. Time of Death
Medical Examir	ner	David Charles	Price	e Jr.			Month March 2	, 2007	Year	0334 hrs
		4a. Facility Name (if not institution, give street a Beaglin Park Dr & Hannibal St	nd number)		4b. City, Tow Salisbur	n, or Location of D y		W	County of Death	
Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birtho				Birth(MM/E	DD/YYYY) 9. Bir Foreig	thplace (State or
Director		202-64-7465 1X M 2]F 22	2	Yrs. Months	Days Hours	Min. 12/:	12/19		nnsylvania
any	ŀ	Usual Residence of Decedent 10a, State 10b, County	I10c	City, Town or	Location					10d Inside City Limits
3		Maryland Wicomico	100.							1 XYes 2 No
rylanc a-f sh	홠	10e. Street and Number		Sc	alisbury	de		10a Citiza	en of What Cou	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	511 Emory Court				B01		-	SA	,
n with	uneral		Decedent Ever ed Forces?	in U.S.	3. Was Decedent of			No- 1		can Indian, Black,
or ite	Fun	1 1	es 2 X	10		uban, Mexican, Pu	erto Ricari, etc.)		White, etc.	
s after	à.	3 Widowed 4 Divorced If Yes, Given or Dates:				No specify:				nite
hour hour	ĘĘ.	15. Decedent's Education (Specify only highes Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)		cedent's Usual Occ ring most of working			16b, Ki	nd of Business/	ndustry
136 hin 72 than than edical	g	12	ge (1-4-01-3+)		Cook			D.	estaura:	nt
ed wit	Completed	17. Father's Name (First, Middle, Last)		`		18.Mother's N	ame (First, Middle			ii C
215 215 be file ntal H rked o	8	David Charles Price,					se Toubo			
21 nould nd Mei is man	의	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (, Zip Code)
MC sl		Denise Jackson/mother			.77 Jacks					
ore, slar of Hez If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3 Remo	val from State		Disposition (Name of or other place)	of cemetery,	Date	20c. L	ocation - City or	Town, State
Page Page ment cant		4 Donation 5 Other Specific		St. Jos	seph Cemet		3/7/07	Pi	ttsburg	n, PA
Salt ermit. Departi mport		21. Signature of Funeral Service Licersee	Con	7	22. Name and Add Hollowa	ress of Facility V Eunera	1 Home.P	rofes	ssional	Association
	4	23a Part I. Enter the disease, or complications to		noth Do not	501 Sno	W HIII R	d., Sali	sbury	77 MD~21	Approximate Interval
Physician /Medical		failure. List only one cause on each line.		eath. Do not e	sinter the mode of dy	ring, such as cardi	ac or respiratory a	irrest, srioc	k, or neart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) August 10 (0)	as a consequen	ce off:						Deall
		Sequentially list conditions.	ao a contocquon	00 01).						
	ner		as a consequen	ce of):				-		
	Examiner	(Disease or injury that initiated C.	as a consequen	ce of):						
		d.		,						
e exec sian at] E	UNPENDED AMEND	ED		-					
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68, certifi nding	ian	past 12 months?	ive birth Pregnant at time o	2 [Fetal death	3 Ectopic pre	egnancy	P	Month [)ay Year
Box 68760 e death certificate be the attending physicate bed for use as the bu	775 I	1 Vos 3 No 9 Unknown	Jnknown	or death 5	Other (Specify)					
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate by After this certificate has been signed by the attending physicianeral director, page 2 should be detached for use as the bur	/ Phys	Part II. Other significant conditions contribut	ing to death but r	not resulting i	n the underlying cau	ise given in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
F.O.	g p						_ 1 _ Y	es 2 🗸	No 3 Prot	pably 4 Unknown
rds requ	 e						24a. Wa	s an opsy		topsy findings available completion of cause of
ecc he lav ite has	Completed	-					per	formed?	death?	
an: T	Bec	25. Was case referred to medical			26.F	Place of Death (Ch				
Vita hysicia I direc	0	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2	ER/Out	patient 3 DOA	Other N	ursing Home 5	Residen	ice 6 🗸 Othe	: Scene
Division of Vital Records, rs after death In Director: After this certificate has been seled in by the funeral director.	ايّ	1 Notices INC	Date of Injury Month Day Year) 2, 2007			Injury at Work?	28d. Describ		y occurred bject collision	n .
SiOn trend death crtor: y the f	ertification:	1 Natural 5 Pending Mai	2, 2007	0248 h	1 1	Yes 2 V No				
IVISION I or Attendafter death Director:	ţįį	Suicide Could not be	Section 1		n, street, factory, off	ice building, etc.	or Town	State)		ral Route Number, City
Dospita hours hours	Š	20a Cartifus	ecify) Major F						annibal St, Sal	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	(Check only one) 2 Medical Examiner: On the b	asis of examinati							
To with Con	Mec	and man 29b. Signature and title of certifier	ner stated.		29c. Li	cense number		29d D	ate signed (Mo	nth, Day, Year)
		trishe Hes	1 Nr.)	0	.C.M.E.		Marc	ch 2, 2007	
	+	30. Name and address of person who completed	cause of death (Item 23a)						
		Tasha Greenberg MD. Assistar	nt Medical Ex	aminer	111 Penn Stre	et, Baltimore,	MD 21201			
Sta	ate	31. Date filed (Mohr) Pay, Year 3 2007	2. Registrar's Sig	nature	Coarle					

			For State Registrar	State of Maryla		artment of H			jiene og. No. 2007	09504
41	Dhysiai		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic	al		hard	Phippi	T			8, 2007	9.13
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		h	4c. County of De	
	Щ.		26847 Osprey Cir		rs. last birthday)	Hebro	n If Under 24 Hrs.	8. Date of Birth	Wicom	thplace (State or Foreign
	Funeral Director			× 2□ F 59	Yrs.	Months Days	Hours Min.		, Year)	Maryland
Ш			Usual Residence of Decedent					1/25/15		
	nylan ihow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f	cto	Maryland Wicomi	.co	Hebron					1 ⊈Yes 2 No
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow he Mudical Examilian must be notified at	Completed by Funeral Director	10e. Street and Number 26847 Osprey Cir	rcle		10f. Zip Code 21830			10g. Citizen of What (USA	ountry?
	eath re 23	erai	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of Hi	spanic Origin? (S	Specify Yes or No-		nerican Indian,
"	r iten	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No		If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Black, Wh	ite, etc. white
21215-0036	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ KNo	Specify:		Specify:	willce
5-0	72 hc	etec	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occupa	during most of wo	rkıng	16b. Kind of Busines	s/Industry
121	han.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)			
75	Hygie ther t nt, in		12 17. Father's Name (First, Middle, Last	1	MeT	.der	18. Mother's Na	me (First, Middle,	Welding Maiden Sumame)	
Maryland	d be sental	To Be	Richard Ambrose						h hungerfo	ord
χŽ	shoul nd Me marfi	1-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street a	-		r, City or Town, State	
ž	elth a 27 is		Sharon A. Phippi	n/wife	2684	7 Osprey	Circle,	Hebron,	MD 21830	
ore	of He of He roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [TRamewal from Ctata		matory or other plac		Date	20c. Location - City of	r Town, State
Ē	Pag ment ant: i		4 Donation 5 Other (Speci	(y)	pringhi. ardens	ll Memory	3/1	2/07	Hebron,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show amortant: or other traumatic event, in Medical Engiting mantical political and once.		21. Signature of Funeral Service Live	Le (FSP	2:	Holloway 501 Snow	sfuneral Hill Rd	Home Pr	ofessional bury, MD 2	Association 1804
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the done cause on each line.						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Meterry	to fic	Carcin	6 mas .	- + Eg	-oghasus	
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):			•		
		-	Sequentially list conditions, if any, leading to immediate	b. — Due to for as a con	saquence of h					
	uted J nnsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		. ,					
o	be executed icien and burial-transit	Еха	resulting in death) Last	C. Due to (or as a con	sequence of):					
3760,	e y s	cal		d						
89)		Med	IF FEMALE:							
Вох	es that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
P.O.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at time 9☐ Unknown	or death 51	Other (specify)				
	The law requires that the ate bas been signed by the bage 2 should be detache	y Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	underlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	quires n sign							1 2 (Y	′es 2□No 3□	Probably 4 Unknown
000	aw require s been si 2 should t	Completed						24a. Was	an 24b. Were	autopsy findings available completion of cause of
ž	The lav	Eo							rmed? death	?
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case relerred to medical examiner?					ath (Check only o	ne)	
7	S 5	မ	1 ☐ Yes 2 No		2 ER/Outpatie		4 🗆 (4u) Silig i		lence 6 Other (Sp	pecify)
Division of Vital Records,	fer	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	Worl	yat k? Yes 2 ∐No	28d. Describe h	now injury occurred	
isic	Attending r death.	licat	Z Accident investigation 3 Suicide 6 Could not to	OB Blace of Injury	At home, farm, st		163 2 140	28l. Location (S	Street and Number or	Rural Route Number.
D	after Dire	Certification:	4 Homicide determined	building, etc. (Sp	ecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tox	vn, State)	
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier the Certifying P (Check only one) 1. Certifying P 2 Medical Exe	hysician: To the best of my miner: On the basis of exar and manner stated.	knowledge, dea nination and/or in	th occurred at the tin	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier	V/ n.	0	29c. Licens			29d. Date signed (Mo	nth, Day, Year)
	. ^		1 YE			0	306	90	3/12/0	7
	10 M		30. Name and sedress of person who	completed cause of death of the second secon	(Item 23a) (Type	, Print)	Germ	11 54	5.1.1	10-1 M D
	Sta	ite	31. Date filed (Month, Pery, Year)	32 Registrar's S	ignature	13 2.	ms-/ - 0 /	, ,,	7 4 / 6 / 6	-)
E	Registi		MAR I 9	Libreur 1	15. A	SON (I)				

			For State Registrar	State of Maryla		artment o				giene	07	095	05
4	Physici		1. Decedent's Name (First, Middle, Last) Laura Mae Rollin						2. Date of Dea Month March 8	Day	Year	3. Time of D 7:09A	Death M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location				y of Death		
16		्री 🖈	Washington Advent	ist Hospital		Takoma					gomer	У	
	Funeral Director		5. Social Security Number 577 03 8364 6. Security Number 10	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Birtl (Month, Day 10-09-1	, Year) .912	9. Birth	place (State or and	Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				· · · · · · · · · · · · · · · · · · ·		10d. Inside City	Limits
	Maryli f aho	ţo	MD Prince	Georges F	lyattsvi	11e						X□Yes 2	2 🗌 No
	n the	Director	10e. Street and Number			10f. Zip Coo	de			10g. Citizen of	What Cou	ntry?	
	th wit	alD	5805 Queens Chape	1 Road		20782				USA			
336	I within 72 hours after death with the Maryland ilene. Itene. Itene. Itene. Itenewalte Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent If Yes, specify (1 ☐ Yes 2 ☐X	Cuban, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)		ack, White,	can Indian, etc. Thite	
2-0	72 hou	ted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Oc	ccupation	st of worki	ina	16b. Kind of I	Business/Ir	ndustry	
2121	d within piene. r then the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Hom	kind of work do DO NOT use re lemaker	atired)			Own H	ome		
Maryland 21215-0036	should be filed vod Mental Hygie marked other imatic avant, III	To Be C	17. Father's Name (First, Middle, Last) Hugh Edwards						(First, Middle, Hicks	Maiden Suma	me)		
	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship (Ty Marjorie Ann Hende	, ,		ng Address <i>(Str</i> Butterw			al Route Numbe Wash:	ir, City or Town ington,		20016	
Baltimore,	一五百五	1	20a. Method of Disposition 1 Burial 2 Cremation 3 F		b. Place of Dispo cemetery, cre	osition (Name o matory or other	of place)		Date	20c. Location			
Ë	Pages ment of tent: If It jury or o		4 □ Donation 5 □ Other (Specify)	Ī	National		,	3-9-2		Falls			
Balt	permit. Pages Department of Importent: If It any Injury or once.		21. Signature of Funeral Service Licens	ee W(2).					seph Gav ,NW Wasl				
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	<i>V</i>	leath. Do not en		dying, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Betw Onset and De	reen
100	/Medical Examiner		disease or condition resulting in death)	Due to (or as a con		nra							
	uted i insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):								
,092	ate be executed nysicien and he burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or as a con	sequence of):								
Вох 68	ath certifica attending plor use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	⊒Ectopic pregn ⊒ Other (s <i>pecif</i> y					ate of delivionth		ear
ds, P.O.	uires that the de signed by the a ld be detachad	by	Part II. Dther significant conditions co	ntributing to death but not	resulting in the I	underlying causi	e given in Part	1.				the cause of de	
Records,	The law require ate has been sing page 2 should it	Completed							24a. Was autor perfo	rmed?	Were aut prior to co death? 1 \sum Yes	opsy findings a ompletion of ca 2 No	vailable use of
Vital	certificate	BeC	25. Was case referred to medical examiner?						h (Check only o				
of	Phys this ral dii	2	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital: 1 ☑ Inpatient 28a. Date of Injury (Month, Day Yea			Other: 4 N		ome 5 Resid			ıfy)	
Division	the the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - A	At home, farm, s		1 Yes 2 tice]No	28f. Location (S		nber or Rui	ral Route Numb	ber,
Ö	ital or A								in the	We.		422	222
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier 1 △ Certifying Phy (Check only one) 2 ☐ Medical Exami	rsician: To the best of my iner: On the basis of examand manner stated.	knowledge, dea nination and/or ii	nvestigation, in	my opinion, de	ath occur	red at the time,	date and place	and due	to the cause(s)	!
	Withi Com	Σ	29b. Signature and title of certifier				cense number 12936			29d. Date sign			
	1		30. Name and address of person who c		(Item 23a) (Type		-			PON E	20 2	w17	
100	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 2 200	32 Registrar's S	ignature								

DHMH 17 Rev 1/2001

			for State Registrar	State of Mar	yland / Depa <i>Cer</i>	rtificate of I		,	giene Reg. No. 🤈 🏻	0.7	09506
347	Physici	an	Decedent's Name (First, Middle, Las Marilyn	t) C. Rahnama				2. Date of Dea Month	Day	Year	3. Time of Death 11:00p M
7	/Medio		4a. Facility Name (If not institution, give			4b. City. Town. or	Location of Death	March 6,	4c. County	of Death	II. OOP III
7	EXAMIN	er	Montgonery Genera			01ney				tgomer	U.
	Funeral		5. Social Security Number 6. Se	ex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		ace (State or Foreign ry)
١.	Director		217-32-4337	□M 2xF	70 Yrs.	Months Days	Hours Min.	(Month, Day			ry) York, NY
	pu ,		Usual Residence of Decedent		On City Town and						
	aryla shov d at	7	10a. State 10b. County		loc. City, Town or Lo					10	od. Inside City Limits
	he M 8a-f	Director	Maryland Montgome	ry	S	ilver Sprin	ng				1 ☐ Yes 2 K No
	with the		10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Count	ry?
	sath seath	Funeral	3559 South Leisure W	orld Blvd., A		209				S.A. e - America	an Indian
	ter d	'n	11. Marital Status 1 □ Never Married 2 🛣 Ma <i>rr</i> ied	Armed Forces? 1 ☐ Yes 2 😿 No	er III 0.3.	Was Decedent of Hi f Yes, specify Cuba	in, Mexican, Puerto	o Rican, etc.)		ck, White, e	
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show diral Examiner must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	I∐Yes 2⊠ No	Specify:		Specify	v: U	hite
Ö	2 hou	led	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occup	ation		16b. Kind of B		
215	hin 7 sn "n Medi	ple	(Specify only highest grain Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give life. L	kind of work done o DO NOT use retired	luring most of worl)	king			
21215-0036	d wit	Completed	12			Homemaker	<u> </u>		Ow	n Home	
	be file	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surnan	ne)	
yla	Duld h Meni arked	2	Dominick Romano				Mary	DeVito			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town,	State, Zip	Code)
	l and Health		Diane Roland - Day	ughter		O Bird Song					
0	Pages 1 nent of H nnt; If ite ury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispos cemetery, cren	sition (ivame of natory or other plac	e)	Date	20c. Location -	City or Tov	√n, State
Baltimore,	t. Partmer	1	4 □ Donation 5 □ Other (Specify			aven Cemete		/2007	Silver S	pring,	Maryland
Ba	permit. Pag Department Important: I any injury o		21. Signature of Funer Save Licen	See No.	H	Name and Addressines-Rinald 1800 New Ha	li Funeral			o Mars	vland 2000/
	*		23a Part1. Enter the disease, or composition of the	plications that caused the	e death. Do not ente					-	Approximate Interval Between
	Physician	8 3	Immediale Cause (Final disease or condition		ic Esop	+ D/-C	coac.	1000			Onset and Death
	/Medical		resulting in death)	a. Due to (or as a		HILOGAL	م، عامرات	JOMEN			
19	Examiner		Sequentially list conditions	b							
2	D .≡	iner	Sequentially list conditions, if any, leading to immediate cause. Enter order, in a Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					100	
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
60,	oe ex cian a	Ē		Due to (or as a t	consequence of):						
68760,	ificate be executed g physician and as the burial-transit	edical		.d							
	ag d	/Me	IF FEMALE:	23c. If yes, outcome pf	pregnancy				201.5		
Вох	atten for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	☐Fetal death 3☐	Ectopic pregnancy Other (specify)				te of deliver onth	y Day Year
P. 0.	the d y the	ysi	1 ☐ Yes 2 2 10 9 ☐ Unknown	9□Unknown	ne or death o_	Tother (specify)					
₽.	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	ᄺ	Part II. Other significant conditions co	ontributing to death but	not resulting in the un	iderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
rds	quires n sigr ild be	d by						1 🗆 Y	′es 2□ No	3 Proba	ably 4 □Unknown
00	w require s been sig should b	Completed						24a, Was a	an 24h	Were auton	sy findings available
æ	The la	шс						autop perfor	rmed?	prior to com death?	pletion of cause of
ta	an:] tificat		25. Was case referred to medical				26. Place of Deat			1∐Yes 2	2ENo
>	Physician: The lav this certificate has al director, page 2	To Be	examiner? 1 ☐ Yes 2 No	Hospital: Inpatient	2 ER/Outpatient	t 3 DOA Othe	AP.	ome 5□Resid		er (Specify)	
Division or Vital Records,	ig Ph ter th neral		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of Injury	28c. Injury Work		28d. Describe h			
jor	ath. or: Af	atio	Natural 5 Pending 2 Accident investigation		(injury		res 2 □ No				
<u>8</u>	r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc.	- At home, farm, stre (Specify)	et, factory, office		28f. Location (S City or Tow	Street and Numb	er or Rural	Route Number,
Ω	urs aft urs aft erai Di			17							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical	29a. Certifier (Check only one) Certifying Phy 2	ysician: To the best of or niner: On the basis of ex and manner state	xamination and/or inv	occurred at the time time of the time of time of the time of time of time of the time of t	ne, date and place pinion, death occu	, and due to the or rred at the time,	cause(s) and ma date and place,	anner as sta and due to	ited. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	,		29c. License			29d. Date signe	d (Month, D	lay, Year)
	1		1 1 1	\sim	WD	D35	635	C	MARC H	F 0	2007
	0		30. Name and address of person who o			Print)					
			sock kunn	18111 Prin		Da o	LNEY,	~>	709	332	
	Sta		31. Date filed (Month, Day, Year)	32. gistrar's	Signature	and a	•				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 T.EONARD RICHEY MARCH 11 2:25 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F Director 422-40-8259 Texas 21. 1935 Jan. Usual Residence of Decedent build be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at ¶Yes 2 No Director WV Jefferson Bolivar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 129 Day Street 25425 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Soldier US Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked William Virgil Richey Pages 1 and 2 should 2 Berchie Jewel Patterson and ins ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Effie Richey - Wife P. O. Box 535 - Harpers Ferry, WV 25425 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Providence Cemetery 3/16/2007 Town Creek, AL 22. Name and Address of Facility Eackles-Spencer & Norton Funeral 21. Signature of Funeral Service Licenses Robert M970 Home - Harpers Ferry, W 25425 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Precuonia /Medical Due to (or as a consequence of) Examiner Metastatic Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's consequence of Examiner law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy performed Yes 2 No death? 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 | Yes 2 | No 1 Depatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician: within 7

> State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

thin 24 hours a

ORIGINAL

h Mhains

Williams

32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 1 3 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Frederick Memorial Hospital

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 12, Day 2007 Year **Physician** 9:50 p. M Ruth M. Rising /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Grantsville Garrett Goodwill Mennonite Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 18, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days ⁷1919 Hours New York Yrs. 87 144-26-4255 Director Usual Residence of Decedent death with the Maryland -how 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Meniel Hygiene. Important: If Item 27 is marked other then "nature!", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examinar must be notified at once. Oakland MD Garrett Funeral Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 USA 655 Ben DeWitt Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 white 1 Yes 2X No Specify: Specify: Be Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 years Registered Nurse Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marion Wheeler Robert Harmer Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 655 Rep DeWitt Rd., Oakland, MD 21550 19a. Informant's Name/Relationship (Type, Print) Patricia M. Copeland/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Old Brick Reformed Ch Cem. Mar 16, 2007, Marlboro, NJ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Newman Funeral Homes, P.A., P.O. Box 275 Umare 179 Miller St., Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bilian **Physician** obstruction mo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death bbt not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 YNo 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed?

1 Yes 2 No of Vital : After this certifice a funeral director, p Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only of e Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Division Natural
Accident
Suicide 5 Pending s efter dea. 1 TYes 2 TNo investigation 6 ☐ Could not be within 24 hours efter der To the Funaral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) To the ! and manner-stated. 29b. Signafure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ulw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) marganeta Kaiser Mod 31. Date (iled (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 14 200

7-02038 dward Alton Ro	_			or Print ir e of Maryla			ent of	Health				ene		201	37	09509
Physicia Medical Examin	n/ ier	Registrar 1. Decedent's Name (Firs			ROGE						N.	Date of De Month March 15	Day 5, 2007	Year 7		3. Time of Death 2029 hrs
		4a. Facility Name (if not i 5921 Addison R		give street and nu	mber)			4b. City, Tov Seat P		ocation of E nt	Death		- 1	c. County of Prince Ge		s
Funeral Director		5. Social Security Numbe) 1	Sex	7. Age (Ir 56	n yrs. last birth	nday) Yrs.	If Under Months			Min.	Date of B	,	/DD/YYYY) 50	9. Birth Foreign Cour	nplace (State or WASHINGTON DC
uth the Maryland 23a or 28a-f show any notified at once,	Director		County	GEORGE '		CAPIT		HEIGH					10g. Cit	izen of Wha		10d. Inside City Limits 1 X Yes 2 No
the la or	— L	5921 ADDIS 11. Marital Status 1 Never Married 2	2 X Marrie	12. Was Dec	rces?		If Ye	s Decedent es, specify (Cuban,	panic Origin' Mexican, Pi				S.A. 14. Race - White,	etc.	an Indian, Black,
C1 3 —	Completed by	3 Widowed 4 15. Decedent's Education Elementary/Secondary	on (Specify	ed If Yes, Give Yea or Dates: only highest grad College (1	e comple	d	Decedent during mo	ost of working	ccupation	specify: on (Give kin DO NOT us		done		Specify: Kind of Busin	ness/In	ACK
# # # # # B E I	<u>a</u> [12th 17. Father's Name (First, UNKNOWN	·	,				SIEREE	1	8.Mother's N	A RO	OGERS	Maiden			
MD id 2 sho ulth and in 27 is	_	19a. Informant's Name/ReCECILIA ROG 20a. Method of Disposition 1 Recurrence Survivors 2 Cr	ERS/W	IFE	m State	5 20b. Place of	921 f Disposi	ADDIS	ON	ROAD		ral H	EIGI	City or Town, HTS, MA Location - C	RYL	AND 20743
Baltimore, permit Pages I ar Department of Hea Important: If ite injury or other tr	-		ther Speci	ify:	C	RESURE	RECT:	ION C	ddress	of Facility	J.	B. J1	ENKI	NS FUI	NER/	AL HOME
Physician Modical Examiner		23a. Part I. Enter the dise failure. List only one Immediate Cause (Final or condition resulting in c	e caluse on disease	each line.	clero	tic card	t enter th	ne mode of	dying, s	such as card	diac or res	spiratory ar	rest, sh	ock, or hear	1	Approximate Interval Between Onset and Death
id sit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death	ate Causs itiated	b. Due to (or as a c. Due to (or as a	conseque	ence of):										
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Box 68760, e death certificate be ex the attending physician ed for use as the burial		IF FEMALE: 23b. Was decedent pregn past 12 months? 1 Yes 2 No 9	uant in the	23c. If yes, of Live b	outcome of irth ant at time		Fet	tal death her (S <i>pecif</i>	3 [Ectopic pi	regnancy		23	d. Date of de Month	elivery Da	ay Year
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of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should be	Completed by	25. Was case referred to	medical					26	Place	of Death (CI	heck only	1 🗸 Yes	psy ormed?	prii de:		opsy findings available empletion of cause of 2 No
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	L B	examiner?	No Pending Investig	28a. Date (Month	npatient of Injury Day,Year)	lament .	itpatient	3 DO.	A C. Injur	Othor:	lursing Ho	ome 5		ence 6 🗸		Scene
Division ospital or Attendia hours after death neural Director: /	Certification:	3 Suicide 6 4 Homicide	Could n determin	ot be 28e. Plac	e of Injury	- At home, far	rm, stree	et, factory, c	office bu	uilding, etc.	28f	. Location or Town,		and Number	or Rura	al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	edical	one) 2 Medi	cal Examir	ician: To the bes ner:On the basis of and manners	of examina			tion, in my d	pinion,	death occur			e and pl	ace, and due	e to the	cause(s)
	Σ	29b. Signature and title of	hall,	M					C.C.N	number				rch 16, 20		th, Day, Year)
R		30. Name and address of Pamela E. Sput	hall, MD			h (Item 23a) I Examiner	r 11	1 Penn S	Street	, Baltimo	re, MD	21201				
Sta Registi		31. Date filed (Month, Da	y, Year) 2007	32. Re	gistrar's \$	Signature	D									n

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Amended Item 23e per Physician 03/19/2007 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 200^{Year} Robey 1220 PM Ongalo Linda */Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Jan. 8, 1953 Carroll Hospital Center Carroll 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K F Country) Finland 54 218-66-0653 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f sh must be notified 1 ☐ Yes 2 No Directo Maryland Carroll Union Bridge 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 943 Winters Church Road 21791 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or item edical Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ 3 Widowed 4 Divorced White Completed the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William S. Ongalo Ruth Michels ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 8 Robert R. Robey/ husband 943 Winters Church Rd. Union Bridge, MD 21791 item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 3/12/2007 | Sykesville, MD 21. Signifule of Funeral Service Licen 22. Name and Address of Facility Hartzler Funeral Home (a) Marine (V. 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronery Vascalas Atheroscleratic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has b irector, page 2 s autopsy performed 2 1 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpletely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 State

within 2

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 1 3 2007

I J. Man,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert C. Mass 114 British Conf. 32 Registrar's Signature

Registrar

29c. License number

032822

29d. Date signed (Month, Day, Year)

07-01760 Dejuan Martez Rounds Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		- For State	,	Certi	ficate of	Death		Re	eg. No.	
Physicia		Re qistrar 1. Decedent's Name (First, Mid	ldle,Last)					2. Date of Deat	h	3. Time of Death
ledical Exami		Dejuan Marte	z Rounds					Month March 5, 2	Day Year 2007	2210 hrs
		4a. Facility Name (if not institut	tion, give street and num		4	b. City, Town, or	Location of	Death	4c. County o	
		Worcester Highway	at Whaleyville Roa	d		Bishopville			Worceste	
Funeral	П	5. Social Security Number	6. Sex 7.	Age (In yrs. last	t birthday)	If Under 1 Year			th (MM/DD/YYYY)	9. Birthplace (State or Foreign
Director	- 1	216-08-4183	1 XM 2 F	24	Yrs.	Months Days	s Hours	Min. Nov 8	, 1982	Country) MD
	_ L	Usual Residence of Decedent								1
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daryland 28a-f show Lat once.	Director	10e. Street and Number		<u> </u>		10f. Zip Code		1	0g. Citizen of Wh	at Country?
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with ns 23	<u>a</u>	11. Marital Status		dent Ever in U.S.				? (Specify Yes or No	- 14. Race White	- American Indian, Black,
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ifter (II", o	by F	3 Widowed 4 D	Divorced If Yes, Give Year or Dates:		1 🗌	Yes 2 X No	specify:		Specify:	Black
ours a		15. Decedent's Education (Sp	pecify only highest grade	completed) 1		t's Usual Occupat ost of working life			16b. Kind of Bus	siness/Industry
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5-0036 led within 7 Hygiene. Lother than	Ĕ	11th				n/a	10.11	No. of Control of the latest and the		/a
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2121 ould be fi Mental marked ic event,	o Be	George E. Joh 19a. Informant's Name/Relatio	nson, III		I 10h Mailing	Address (Stron	Larce	ene Rounds per or Rural Route Nur	Jonnson	n State Zin Code)
D 2 shoul and N is m	۲									i, otate, zip oode,
MD and 2 sho salth and 2 ris	ŀ	Larcene R. Jo 20a. Method of Disposition	hnson/mothe	20b. Pla		BOX 391 ition (Name of ce		lin, MD 21	20c. Location -	City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens than "matural", or items 23a or 28a-f she important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once			ion 3 Removal from	n State cre	ematory or oth	ner place)				
im Page ment tant:		4 Donation 6 Other	Specify:	Cre	natory	of Delm	<u>arva </u>	3/10/2007	Delma	r, DE
Salt ermit repart mpor njury		21. Signature of Funeral Servi	de Lieensee		122. N	lame and Address	s of Facility Watso r	n Funeral	Home	
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760, ficate be g physic the bur		IF FEMALE: 23b. Was decedent pregnant in		utcome of pregna		etal death 3	Ectopic	pregnancy	23d. Date of Month	Day Year
Ox 687 eath certific	sician	past 12 months?		nt at time of dea	th =	her (Specify)				
Box 68 death certif the attending	ıysi	1 Yes 2 No 9	Jnknown 9 Unknov	vn						
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Ision of Vital Records, Attending Physician: The law require releath. ettor: After this certificate has been si by the funeral director, page 2 should b	<u>ا</u>	1 Yes 2 No 27. Manner of Death	28a. Date of	of Injury	28b. Time of	Injury 28c. Inju	ury at Work?		how injury occurr	
on C nding th. r: Af	<u>.</u>	1 Natural 5 P	ending Mar 5, 20	Day, Year) 007	2206 hrs	1	Yes 2	No Driver auto	auto collisior	d.
Division ratendii rs after death.	<u>g</u>		vestigation 28e. Place	of Injury - At hor	me, farm, stre	et, factory, office	building, etc			per or Rural Route Number, City
Divispital or spital or sours after ours after filled in filled in l	Certification:		ould not be etermined (Specify)	Major Road	l / Highway	y		or Town, Worcester H	wy & Whaleyvil	lle Rd., Bishopville, MD
Hospi 4 hou Funer ely fil		29a. Certifier	g Physician: To the best	of my knowledg	e, death occu	rred at the time, o	date and pla	ce, and due to the cau	se(s) and manne	r as stated.
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as:	Medical	(Check only one) 2 Medical E	Examiner: On the basis of and manner st	f examination an	nd/or investiga	ation, in my opinio	on, death occ	curred at the time, date	e and place, and o	due to the cause(s)
	ğ	29b Signature and title of cer		aleu.		29c. Licen	nse number		29d. Date sign	ned (Month, Day, Year)
20		In A Kive	Hall MA			0.0	,M.E.		March 6, 2	2007
Yell .		30. Name Transs of per	son who completed cause	e of death (Item:	23a)				-1	
50	1	Pamela E. Southall	, MD Assistant !	Medical Exar	niner 11	11 Penn Stree	et, Baltim	ore, MD 21201		
ş ,	tate			gistrar's Signatui	re					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Robert **Physician** 17:12 PM Swith March 06 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery General Hospital 01ney Montgomery If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Min. 1 X M 2 □ F 578.10.8455 Yrs. Director 93 11/3/1913 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3641 South Leisure World Blvd., #1A U.S.A. Funeral 20906 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2K No Specify þ White 3 X Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Owner** Service Station 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ray V. Smith ဥ Odessa Brownhill Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy McCullough - Daughter 821 Vanderbilt Terrace S.E., Leesburg, Virginia 20175 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/10/2007 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw

Physician /Medical

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r than "natural", or items 23a or the Medical Examiner must be

ages 1 and 2 should be fill ont of Health and Mental Ht: If Item 27 Is marked otty or other traumatic even

filed within 72 hours after death

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Division or Vital

sician and burial-trans the attending pl signed I page 2

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To the Hospital or Attending within 24 hours after death

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Immediate Cause (Final disease or condition resulting in death) antowor Myocardial Interdion Due to (or as a consequence of kerosclezosie provou if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Cardionyopath Meta 2 No 3 Probably 4 Unknown 1 Yes Completed lax discas 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Anemia 2 No 1∏Yes 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident (Month, Day Year) 5 ☐ Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 06, 2007

DHMH 17 Rev 1/2001

State

Registrar

nth, Day, Year)

2007

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cause of death (Item 23a) (Type, Prin 3801 Prince Philip

		for State Registrar					,		tificate				ental Hyو ا	Reg. N	0	nn	7 0	951
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/Medic			ine R.										March	_				рт м
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il Hyg other ent, i	Be C	17. Father's Name	(First, Middle,	Last)						1	8. Mother's	's Name	(First, Middle,	Maide	en Surnai	me)		
uld be Menta Irked Itlc ev	To B	William	Tomlin	son							Mary		Schar	din	g			
2 sho and I is ma		19a. Informant's N	ame/Relations	hip (Typ	e. Print)		1	9b. Mailir	ng Address (S	treet an	d Number	or Rura	l Route Numb	er, City	or Town	, State, Z	ip Code)	
and lealth m 27 her tr		Paul S1		Son			T				d Dr.		aithers				_	
ges 1 If ite or ot		20a. Method of Dis 1 ☐ Burial 2	position Cremation	3 □Re	emoval from	State	ceme	etery, crei	sition (Name natory or othe	er place)		-10-	ate 0.7			- City or 1 Shure	Fown, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 21. Signature of F	5 Other (S		^		Nat.		Crema		-:							
permi Depa Impo any is	d a	≥1. Signature of	olusa 1	Mila	Dan								eph GAw N.W. W					16
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/Medical		disease or condition resulting in death)	ווכ	a.	_		consequen											
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ificate g hys	edic			d.														
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de att	sicia	in the past 12 1 ☐ Yes 2	months?			nant at t	Pretal de ime of deatl		Ectopic preg Other (spec						М	onth	Day	Year
that the denet by the detached	Phys	9 □ Unknowr																
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The law ate has t page 2 s	Completed												24a. Was autor		!	Were au prior to c death?	topsy findin ompletion o	gs available if cause of
ilclan: Th certificate rector, pag		OF Management	mand he mandian										1 Yes	2 / N		1 Yes	2□ No	
Attending Physician: 1 or death. rector: After this certifications by the funeral director, p	o Be	25. Was case refe examiner? 1 ☐ Yes 2 📉			ospital:	l Inpatien	t 2 🗆 EP	/Outpatier	nt 3 DOA	Other:			(Check only o		6 🗆 🗆	hor /0-:		
g Phy er this eral d	H (27. Manner of Dea	th		28a. Date	of Injury	/ 28	b. Time o		Injury a Work?	41 Nurs		ne 5 Residence Reside				ary)	
ath. nr: Aft ne fun	tification:	1 X Natural 2 Accident	5 ☐ Pendin investig	gation	(IVIOI	nth, Day	rear)	Injury	М		es 2□N	lo						
or Attend ter death lirector: , n by the f	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could determ		28e. Plac	e of injur	y - At home (Specify)	, farm, str	eet, factory, c	ffice		1	28f. Location (S City or Tox	Street a	and Num	ber or Ru	ral Route N	umber,

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the tending hysician and completely filled in by the funeral director, page 2 should be detached or use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

3

State Registrar

9

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) MAR 12

Thomas Havel, M.D.

29b. Signature and title of certifier

egistrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MD 6104

29d. Date signed (Month, Day, Year)

March 9,2007

		1	For State Registrar		State o	f Mar	yland		artmen <i>tificat</i>				lental Hyg	giene Reg. No.	200	7	095	5 1 4
	- 2		Decedent's Name (Firs	t, Middle, Las	st)								2. Date of Dea	ath Day	Yea	-	. Time of D	eath
	Physicia		MARY A.	SCOL	NIK								MARCH 9,	-			1:26	A ^M
	/Medic		4a. Facility Name (If not in	nstitution, give	e street and nu	mber)			4b. City,	Town, or	Location	of Death		4c.	County of De	eath		
		·	3700 CALVERT						KENSI		I I I Inda	= 0.4 Uro	8. Date of Birt		TGOMERY		/C4-A	Comian
	Funeral		5. Social Security Numbe		ex □M 2⊠F	7. Age		ast birthday) Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		Country)	e (State or	roreign
	Director	-	007-10-2229 Usual Residence of Dece	edent			92						JAN. 7,	LATO	MAI	NE		
2	M M			County			10c. City	, Town or Lo	cation								Inside City	
1	mary fled	ţċ	MARYLAND MO	NTGOMER'	Y		KENS	INGTON									1 Tes	2 K 1N0
4	or 288	Director	10e. Street and Number			-			10f. Zi	Code				10g. Citiz	zen of What	Country	?	
1	23a c		3700 CALVERT P	LACE						895_				· · · · · ·	U.S.A. 14. Race - A	morican	Indian	
	r oear	Funeral	11. Marital Status		12. Was Dec Armed Fo	orces?		3. 13.	Was Dece If Yes, spe	dent of H ecify Cuba	lispanic O an, Mexic	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	•	Black, W			
9	or i	by F	1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ □		1 ☐ Yes If Yes, G Year or D	ive)		1 ☐ Yes	2💢 No	Specify	<i>/</i> :			Specify: W	HITE		
Š	illed within 72 hours after beauf with the maryanin Hygiene. ther than "natural"; or items 23a or 28a-f show wit, the Medical Examiner must be notified at		15. [Decedent's E	ducation			16a. Dece	dent's Us	ial Occup	ation			16b. Ki	nd of Busine	ss/Indus	try	
<u> </u>	in 72 in "in Medic	plet	(Specify on Elementary/Secondary	-	ade completed) College ()	(Give life.	kind of w	ork done ise retired	auring mo d)	st of work	ang					
7	Hygiene. Hygiene. ther than	Completed	Liementary	(0 .2)	4			SOCIAL	WORK	ER					E OF MA	INE		
2	be tile stal Hy st othe event,	Be C	17. Father's Name (First,	, Middle, Last)						18. Moti	her's Nam	e (First, Middle					
<u>a</u>	should to	흔	LOUIS		ABROMSO	N		1			ANNIE				ELMAN	a Zin Co	ada)	
	2 sho		19a. Informant's Name/F	Relationship (Type. Print)			1					ral Route Numb			e, 21p 00	ide)	
o	s 1 and 2 should be lined within 72 hours after death with the marysal if Healith and Menhal Hygiene. If Healith and Menhal Hygiene. If the 21 is marked other trian "natural", or items 23a or 28a-f show tem 21 is marked other trian "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		STEPHEN SCOLNI 20a. Method of Disposition				20b. P	lace of Dispo	osition (Na	me of			MAC, MARY	20c. Lo	20854 cation - City	or Town	, State	
	Pages nent of I int: If its iny or o		1 ⊠ Burial 2 □ Cre	emation 3		State		emetery, cre			ce)	02/11	/2007	ADELE	PHI, MAF	PYT.ANI)	
Бапппо	permit. Pages Department of Important: If it any injury or conce.	1	4 □ Donation 5 □ 21. Signature of Funeral				MII.	LEBANO!	2. Name a	nd Addre	ss of Fac	ility	75-05-5-1					
Ď	Dep Imp any	e il	1 aman	da	Lude	wie	2)	HI	NES-R 800 N	INALD] EW HAN	I FUNE 1PSHIR	RAL HO E AVE	OME, INC. NUE, SILV	ER SP	RING, M	ARYLA	ND 209	104
	4. 6		23a. Part1. Enter the dis	sease, or con	plications that	caused each line	he death									A	pproximate iterval Bety	e ween
F	Physician		Immediate Cause (Final disease or condition					MENTIA									nset and E EARS	ream
	/Medical		resulting in death)		a			uence of):		-								
	Examiner	L	Sequentially list condition	ons,	b											-		
Br v	pe sit	Examiner	Sequentially list condition if any, leading to immediate. Enter the Cause (Disease or injury)	liate	Due to	o (or as a	conseq	uence of):								15		
	be executed ician and burial-transit	хац	that initiated events resulting in death) Last		c	o (or as a	conseq	uence of):										
20	ate be executed nysician and he burial-transit	calE		•	► d													
	ificate g phys as the											_						
ROX	death certifica e attending ph d for use as th	N.	IF FEMALE: 23b. Was decedent pre		23c. If yes, o	utcome p			□Ectopic	pregnanc	v				23d. Date of Month	,		Year .
n n	deat le atte	sicia	in the past 12 mon 1 ☐ Yes 2 ☐ No			gnant at			Other (WOTH		ay	Gui
л О	The law requires that the de ite has been signed by the a bage 2 should be detached f	Physician/Med	9 Unknown Part II. Other significan				t pet roo	ulting in the	undorlying	cause di	von in Pa	rt I	23e Did	tobacco	use contribu	te to the	cause of d	leath?
ś	res th signed be de	Ş	Part II. Other significan	it conditions	Contributing to	dealii bu	11 1101 163	diding at the	underlying	ouddo g.	1011 III I						oly 4 □l	
Records,	w requir been si should i	Completed											24a. Wa	e an	24h Wer	re autons	y findings	available
ec Sec	e law has t je 2 s	Jg I				·							auto	opsy formed?	dear	th?	y findings pletion of c	ause of
			25. Was case referred t	to modical							26 PI	ace of Dec	1 Yes ath <i>Check onl</i>	2 X No	0 1 1 1	Yes 2	∐ No	
Vita	ysician: The is certificate hadirector, page	o Be	examiner?	to medical	Hospital:] Inpatie	nt 2	ER/Outpatie		OA Ot	hor		lome 5 Res		6 □Other (Specify)		
ō	Attending Physician: If death. ector: After this certification by the funeral director,	11-	27. Manner of Death		28a. Dat		ry	28b. Time Injury	of	28c. Inju			28d. Describe					
0	tending leath. tor: Aft the fun	atio	2 Accident	☐Pending investigation	on .	лии, Бау	rour	,,	М		Yes 2	□No						
Division or	or Attendate and er death Director:	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not determine	a 206. Fia	ce of inju	ıry - At h	ome, farm, s <i>fy)</i>	treet, fact	ory, office	•		28f. Location City or To	(Street a. own, Stat	nd Number (e)	or Rural i	Route Nun	ıber,
	ospital o hours at uneral Di ly filled in	Se								1 1 1 1 1 1	**			0.001100/1	a) and mann	or ac eta	tod	
	To the Hospital or At within 24 hours are d To the Funeral Cirect completely filled in by	Medical	29a. Certifier 1 X (Check only 2 Cone)	Certifying F Medical Ex	aminer: On the	he best of basis of anner sta	f examina	owledge, dea ation and/or	ain occurr investigati	on, in my	opinion,	death occ	e, and due to th urred at the time	e, date ar	nd place, and	d due to t	the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title	of certifier	and ma				2	9c. Licer	nse numb	er		29d. Da	ate signed (f	Month, D	ay, Year)	
•	FIFE		m/a	·L.	011	1		1		MD159	01			MARCI	H 9, 200	07		
,	7		30. Name and a ress	of person wh	o concleted ca	use of d	eath (Ite	m 23a) (Type	e, Print)	צנבשיו	OT.				200	-		
			MICHAEL GRADY		/	HEDRA	AL AV	ENUE, W		TON,	DC 20	016						
	St	ate	31. Date filed (Month, L	Day, Year)	กก7 ³		ar's Sign		hants	,								

DHMH 17 Rev 1/2001

DIVISION OF VITAL DECORDS, P.O. DOX 007 00,		6	0
To the Hospitai or Attending Physician: The law requires that the death certificate be executed	Ph // E>	k,pl	perm
within 24 hours after death.	y: Mi	40.	Depa
To the Funeral Director: After this certificate has been signed by the attending physician and	sic ed mi		impo
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cia ica ine		any i

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of Ho <i>rtificate of E</i>			iene _{eg. No.} 20	07	09515
25	Dhysisi		1. Decedent's Name (First, Middle	e, Last)				Date of Deat Month	Day	Year	3. Time of Death
	Physici: /Medic		Daniel Ower					March			4:00 A ^M
	Examin	er	4a. Facility Name (If not institution			4b. City, Town, or			4c. County		l o
	Funeral		Charlotte Hall 5. Social Security Number		enter e (In yrs. last birthday)	If Under 1 Year	te Hall	8. Date of Birth		Mary 9. Birthpl	ace (State or Foreign
	Director		252-12-5771	1 X M 2□ F	88 Yrs.	Months Days	Hours Min.	Sep. 5,	1918	Geo	rgia
1961	pu >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ncation				1/	Od. Inside City Limits
	faryla shov	ō		lvert	Solomor					'	1 ☐ Yes 21X No
	the A 28a-i notifi	rect	10e. Street and Number		COTOMO	10f. Zip Code		1	0g. Citizen of V	What Count	try?
	h with	al Di	11740 Asbury	Circle		206	888			USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and so or 28a-f show then 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	If Yes, Give	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
21215-0036	72 hou natura licai E		15. Deceden	it's Education st grade completed)	16a. Dece	dent's Usual Occupa	ition	ina	16b. Kind of Bu	usiness/Ind	lustry
21	within 7 iene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	kind of work done d DO NOT use retired)		"ig	Sto	to IIn	iversity
	filed w Hygiel kther th		17. Father's Name (First, Middle,	(ast)	Adril	inistrator	18. Mother's Name	e (First, Middle, I			Iversity
Maryland	2 should be filed w n and Mental Hygie Is marked other ti raumatic event, th	To Be	Walter P. Sp:				Etta	, (1 ,iist) imagio, ,	maid on barrian	Ow	en
37	should ind Men s marke umatic	Ĕ	19a. Informant's Name/Relations		19b. Maili	ng Address (Street a	and Number or Run	al Route Number	r, City or Town,		
	1 and 2 Health a tem 27 Is		Jan M. Spinks	(wife)		Asbury C		208 Sol	lomons,	MD 2	0688
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 ☐ Bemoval from State	20b. Place of Dispe	osition (Name of matory or other place) Mar	13	20c. Location -	City or To	wn, State
ţi.	Pages tment of tant: If its		4 □ Donation 5 □ Other (5	Specify)	Lee Cren		20		Clinton		
Bal	permit. Pages t an Department of Hea important: If Item any injury or other once.		21. Signature of Funeral Service	Licensee Goff		2. Name and Addres				Calv ngs,	
0			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that caused tonly one cause on each li	the death. Do not en						Approximate Interval Between Onset and Death
	Physician /Medical	ļ	Immediate Cause (Final disease or condition resulting in death)	_a Enc	1 Stage	o de	menti vluins	ia			
	Examiner		,	Due to (or as	a consequence of	a Da	diins	ema 's	disc	2000	3
	h 19	ıer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):	c 1a	yuivi.	3011 3	us	ي رو	
	cuted nd ransit	Examiner	that initiated events	С							
, 0,	e exe sian a uriai-t	Ex	resulting in death) Last	Due to (or as	a consequence of):						
68760,	cate b	dica		d							
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>				te of delive	ery Day Year
<u>α</u>	s that ned by e deta		Part II. Other significant conditi	ons contributing to death b	out not resulting in the u	inderlying cause give	en in Part I.	23e. Did tol	bacco use cont	ribute to th	e cause of death?
rds	w requires been sig should be	ed by						1 □ Y	es 2□No	3 ☐ Prob	ably 4 Unknown
I Records,	sician: The law requ s certificate has been irector, page 2 should	Completed						24a. Was a autops perform	sy med?	prior to cor death?	psy findings available inpletion of cause of
Vital	Physician: r this certifica ral director, I	Be	25. Was case referred to medica examiner?	Hospital:		nt 3DD04 Othe	26. Place of Deat	h (Check only on	ne)		
o	Phy raid	: To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpati		III 3 DOA	4 IN Nursing Ho	me 5 Reside			/)
	Attending Phradensing Phradensing After thiby the funeral	tion	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	ng (Month, Da	y Year) Injury	Work	r? Yes 2 □ No	200. 20001120 110	on many coour	, 0 0	
Division	i or Attend after death Director: /	Certification:	3 Suicide 6 Could 4 Homicide determ	ained 200, Flace of III	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (Si City or Town		per or Rura	l Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifylic (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis of and manner st	of examination and/or in	th occurred at the tim	ne, date and place, pinion, death occur	and due to the c red at the time, c	cause(s) and madate and place,	anner as st and due to	tated. the cause(s)
	To t with To t	Ž	29b. Signature and time of certific	l Star	i Ms	DU S	5092	2	3/2	d (Month,	Day, Year)
İ	10		30. Name and address of person Parul Jani, M		death (Item 23a) (Type tal Road]		ederick,	MD 2067	78		
	Sta Registi		31. Date filed (Month, Day, Year, MAR 1 2 200		rar's Signature	,					

DHMH 17 Rev 1/2001

			For State Registrar		State	of Mary		artment of F rtificate of		d Mental	Hygier Reg. 1	711117	09516
		.4.	Decedent's Nam	ne (First, Middle,	Last)						of Death		3. Time of Death
	Physici /Medic		Jea	n Bo	nnie	Sass	ano			Marc		2007	6:20 A M
	Examin		4a. Facility Name (If not institution,	give street and no	umber)		4b. City, Town, o	r Location of De	eath		4c. County of Dea	
4	Company of the second		Hermitac	e at St				Solomor				Calvert	
	Funeral		5. Social Security N 359–09–5		6. Sex 1 ☐ M 2 🔀 F		yrs. last birthday, Yrs.	If Under 1 Year Months Days	Hours M	lin. (Mon	th, Day, Yes	ar) Co	thplace (State or Foreign puntry)
us,	Director		Usual Residence o			88)			May	14,	1918 11.	linois
	yland now at		10a. State	10b. County		100	c. City, Town or L	ocation					10d. Inside City Limits
	e Mar ta-f sl	Director	MD	Calve	ert		Solomor	ns					1x Yes 2 No
	or 28	Dire	10e. Street and Nu					10f. Zip Code			10g.	Citizen of What Co	ountry?
	ath w	ral	13325 D	owell Ro	_			20688				nited Sta	
	items	Funeral	11. Marital Status	ried 2 Marrie	12. Was Dec	cedent Ever orces? 2 No	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	? (Specify Yes uerto Rican, et	or No- c.)	14. Race - Ame Black, Whit	
-0000	72 hours after death with the Maryland natural", or items 23a or 28a-f show fical Examiner must be notified at	by F	3X Widowed	_	If Yes, G Year or I	ilve		1 ☐ Yes 2 No	Specify:			Specify: V	Mite
5	2 hou	ted	(Sac	15. Decedent's	s Education grade completed	,	16a. Dece	dent's Usual Occup	ation		16b	Kind of Business	Industry
V	ithin 7 ie. ian "r Me	Completed	Elementary/Seco		Ť ·	(1-4or 5+)		kind of work done DO NOT use retired	daring most of t	working			
7	ed wi		12		L		Hon	emaker				Own Home	
<u>a</u> 10	should be filed within ind Mental Hygiene. s marked other than " umatic event, the Me	Be	17. Father's Name Sidney							Name (First, M		,	
5	hould d Me mark matic	ပ္	19a. Informant's N		Chisholm		10h Maili	ng Address (Street	Leona		arkamp		Zin Cada)
2	and 2 sho saith and n 27 Is ma				chuck, So	on		34 Pine 1)657	Lip Code)
בֿי	- I F E		20a. Method of Dis	position		2		osition (Name of matory or other place		Date		Location - City or	Town, State
Dalling	Pages nent of I int: If ite			☐Cremation 5 ☐ Other (Sp	3 □Removal from ecify)	Jale		eek Cemet	1	_12_200)7 H	ollidaysh	ura. PA
2	permit, Page Department of Important: If any Injury or once,		21. Signature of Fi	uneral Service L	icensee			2. Name and Addre		12 20	, 110	orreacy be	,u197 111
<u> </u>	8 9 E 8 9		Will	lon	K. G1	0-	_	Rausch 1	Funera	l Hom	e, P.	A., Ow	ings, MD
			23a. Part1. Enter to shock, or hea	the disease, or o art failure. List o	complications that only one cause on	caused the ach line.	death. Do not en	ter the mode of dyir			tory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause disease or condition resulting in death)	(Final on	_a	auk	inson	s Qu	seas	ع			Onset and Death
	/Medical Examiner		resulting in death)	1	Due to	(or as a co	nsequence of):						
	- Ar	er	Sequentially list co	onditions,	b	or as a co	nse uence of:						
	uted	Examiner	cause. Enter Under Cause (Disease or that initiated events	erivina 🚄									
Š	an an rial-tr	Еха	resulting in death)	Last	Due to	(or as a co	nsequence of):						
20100	ficate be executed physician and s the burial-transit	edical		,	d			***					
	ertific ling p	Mec	IF FEMALE:										22 - 2 - 20
מא	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was deceder in the past 12	months?			Fetal death 3	Ectopic pregnancy	,			23d. Date of de Month	ivery Day Year
j	the de	ysic	1 ☐ Yes 2 9 ☐ Unknown		9□Unki		ordeath 5t	Other (specify)					
Ļ	that ned by deta		Part II. Other signi	ficant condition	ns contributing to	death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e.	Did tobacc	o use contribute to	the cause of death?
SOLUS,	quires in sigr	ed by	_ Qe	ment	tia_					_	1 🗌 Yes	2 ∑% 0 3 □ Pi	robably 4 Unknown
5	aw re is bee 2 sho	plete								24a.	Was an	24b. Were au	utopsy findings available
	The I	Completed								_	autopsy performed Yes 2	Prior to death? No 1 ☐ Yes	completion of cause of 2 ☐ No
2	siclan: The law s certificate has t irector, page 2 s	Be C	25. Was case referexaminer?	rred to medical					26. Place of E	Death (Check			
5	hysic this co	To 1	1 ☐ Yes 2	-			2 ER/Outpatie		4 La Nursing			6 □Other (Spe	cify)
	Attending Physiclan: The I streath. ector: After this certificate he by the funeral director, page	ion:	27. Manner of Dear	5 Pending		of Injury nth, Day Ye	ar) 28b. Time o	Wor		28d. Des	cribe how ir	njury occurred	
2	death ctor: y the	icat	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	ot be lass Blac	e of injury -	At home, farm st	M 1 □	Yes 2 □ No	28f Loca	tion (Street	and Number or B	ural Route Number,
2	after after Direct	Certification:	4 Homicide	determin	build	ding, etc. (S	pecify)	oot, tuotory, omoo		City	or Town, St	ate)	nai rione ivariber,
	ospita hours ineral y filler		29a. Certifier	1 Certifying	Physician: To th	e best of my	knowledge, dea	h occurred at the tir	ne, date and pla	lace, and due	to the cause	e(s) and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one)	2 Medical E	xaminer: On the and ma	basis of exa nner stated.	mination and/or ir	vestigation, in my o	pinion, death o	occurred at the			
	To t To t	Σ	29b. Signature and	title of certifier	211			29c. Licens	e number	751	29d. I	Date signed (Mont $3 - 8 - 0$	h, Day, Year)
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	R		30. Name and add						507 -	0000==	J +	MD O	0650
J	Sta	te	31. Date filed (Mor			Renietro	Signaturo	. Box 15	о∪ / ,	eonar	LOWI	1, MD 20	7030
	Registr			MAR	9 2007		ener St	Sports	•				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) $P^{\,\mathsf{M}}$ Shafer, Sr. 8 2007 9:15 William Robert March 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 400 Chapel Court, #104 Walkersville <u>Frederick</u> If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 0 c t . 8 , 1940 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months 1 ★ M 2 □ F 66 214-36-1345 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√ Yes 2 No Walkersville Maryland | Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 400 Chapel Court, #104 21793 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shafer Alice William Emory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 400 Chapel Court #104, Walkersville, MD 21793 Mary F. Shafer/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ResthavenMemorialGard 3/13/2007 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Parth. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) 20 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MellITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24h Were autonsy findings available 24a Was an 25

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed attending physician and for use as the burial-trar the signed by t page 2 s certificate has this

Division or Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be funeral Certification: After 1 To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by the

_		-	_						_	autopsy performed?	prior to completion death? 1 □ Yes 2 □ No	
25.	Was case refer	red to medical						26. Place o	of Death (Check only one)		
	examiner?	No	Ho	ospital: 1 ☐ Inpatient 2 [☐ ER/Outpatient	3 🗆	DOA	Other: 4 Nurs	sing Home	5 Residence 6	Other (Specify)	
27.	Manner of Death Natural Control Accident	5 Pending investigation		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	1	d. Describe how injury	occurred	
	3☐ Suicide 4☐ Homicide	6 Could not b determined		28e. Place of injury - At building, etc. (Spec	home, farm, stre	et, fac	tory, o	ffice	28	f. Location (Street and City or Town, State)	l Number or Rural Route I	Number,
29	a. Certifier (Check only one)			ician: To the best of my kr er: On the basis of examir and manner stated.								se(s)

29c. License number

D0035152

State Registrar

completely

Medical

29b. Signature and title of certifier

MD

100 S. Center

29d. Date signed (Month, Day, Year)

3.10.07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kump

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 6:10P March 2007 William Smith /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Citizens Care & Rehabilitative Ctr. 8. Date of Birth (Month, Day, Year) Sept. 8,1925 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1(XM 2□ F Yrs. Director 81 Maryland 220-26-6021 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
I other than "natural", or itams 23a or 28a-f ahnum 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f ahow the Medical Examinar must be notified at 1 X Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 1900 Rosemont Ave. U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: 1952-54 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) assembly line worker 5 rubber co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be bs 1 and 2 should be find the first of Health and Mental Hitem 27 is marked of Amos Abner Smith Katie Pauline Sappington ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard C. Smith/ brother 67 N. Main St. Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Resthaven Mem. Gardens 3/12/2007 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bicensee 22. Name and Address of Facility Hartzler Funeral Home attan Libertytown, MD 21762 11802 Liberty Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atteroschrotie Immediate Cause (Final Cardiovasendor **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) sete hes been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No cartificete hes 1 Yes After this cartifice funeral director, p To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: ဥ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of Natural Accident 5 ☐ Pending within 24 hours effer death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and little of o 29c. License number 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD 21701 Robert L. Kaufmann 300 W. 9th St. 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 12

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ralph Arlington Swartz Jr. 8:40 a.M March a 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Hospital Center Bel Air If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2□ F Yrs. 164-30-2104 69 20, 1937 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itеms 23a or 28a-f shov other traumatic event, the Medical Examiner next be notified at 1 XYes 2 No Harford Bel Air Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 207 Kings Crossing Circle Unit 3D 21014 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 20 Married 1 □Yes 2X No 5 1 ☐ Yes 2 ☐ No Specify: Specify: white 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 le marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) manager retail 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Schweikle Ralph A. Swartz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 item 27 wife 207 Kings Crossing Circle Unit 3D, Bel Air, MD21014 Peggy Swartz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it eny injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Unity Washington Cem. ! 3/12/07 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent)e (or as a consequence of): Physician/Medical deteched for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death | Check only one | Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

hin 410, MD

2007

completed cause of death (Item 23a) (Type, Print)

D0059855

M. D. 500 Upper Chesapeake Dr. Beldir, MD

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of artificate of			iene	007	09520
	Physic	ian	Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medi		Bernice	Marie	2	Smi	th	3	9	2007	4:30 P M
	Exami	ner	4a. Facility Name (If not institution, give	•			or Location of Death		4c. Co	ounty of Death	
*		沙髓	129 Hartford Roa		4	Salis				icomico	
	Funeral Director			Sex 7. Ag 1 ☐ M 2 🔀 F	ge (In yrs. last birthday 82 Yrs.	Months Days		8. Date of Birth (Month, Day, 4-18-19	Year) 24	9. Birthp Cour De1a	place (State or Foreign http)
	pu >		Usual Residence of Decedent		140. Ch T						
	anyla ehov	-	10a. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limits
	he M	Director	MD Wicomi 10e. Street and Number	co	Salis						1 ☐ Yes 2 No
	with			,		10f. Zip Code		10	0g. Citize	n of What Cour	ntry?
	eeth	era	129 Hartford Roa	12. Was Decedent	Ever in U.S. 12	2180		poofu Voo or No	USA	Race - Americ	an Indias
Maryland 21215-0036	72 hours after deeth with the Maryland naturel', or Iteme 23a or 28a-f ehow Jital Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	etc.
ŏ	72 hours naturel',	ted	15. Decedent's E	ducation	16a. Dece	edent's Usual Occu	pation		16b. Kind	of Business/Inc	dustry
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yla	2 should be and Mental Is marked c	ည	Walter L. Philli					lae Unkno			
Jar			19a. Informant's Name/Relationship	**			t and Number or Rur				
a)	and lealth im 27		Jerry Swift - so	n	627	Priscilla	Street,		_		
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Baltimore,	it. Pa rtmer rtant njury		4 Donation 5 Other (Special			11 Memor		13-2007	Hebr	on, Mar	ryland
Ba	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service Lice	nsae		2. Name and Addre	PO.	unds Fun			
			23a. Pan 1. Enter the disease, or com- snock, or heart failure. List only	ulications that caused	the death. Do not en	05 E. Mai	n Street.	_Salisbu	ry, N	Marylan	A_21804 Approximate
			shock, or heart failure. List only Immediate Cause (Final				ng, soon as cardiae	or respiratory arre	, ,		Interval Between Onset and Death
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Ö,	e exe ien ar urial-t		resulting in death) Last	Due to (or as	a consequence of):						
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9	entific ling p e as	Me	IF FEMALE:								
P.O. Box	that the death certificate be executed to by the attending physicien and detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		230	d. Date of delive Month	ery Day Year
	The law requires that the site has been signed by the bage 2 should be detache	by Pt	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause gr	ven in Part I.	23e. Did tob	acco use	contribute to th	ne cause of death?
rds	w require been sig should b	a pa						1 ⊡ Ye	s 2 🗆 N	No 3 ☐ Prob	ably 4 Unknown
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Division of Vital Records,	or Att after d Direct in by	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str City or Town,	eet and N State)	lumber or Rura	l Route Number,
	Hospital		29a, Certifier 1 Certifying Pt	,						i	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only one)	niner: On the best niner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	n occurred at the ti	me, date and place, opinion, death occurr	and due to the ca red at the time, da	use(s) an ite and pla	d manner as st ace, and due to	ated. the cause(s)
	To the	Σ	29b. Signature and title of sertifier			29c. Licens	se number	29	d. Date s	igned (Month, I	Day, Year)
L	CO,		1			D	54129			3/12/	(P)
	, D.,		30. Name and address of person, who	completed cause of d	leath (Item 23a) (Type,	Print)	1	201 00			
7	V-		Alm nans	M 10	to Rower	s4. Su	lishy w	0 41	804		
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 13		ar's Signature		1				
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ORIGINAL

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	Physicia		1. Decedent's Name (First, Middle,	Last)			<	tair	2. Date of D Month March	eath Day	Year	3. Time of Death
	/Medic	al -	Paul I					- • •		9	2067	0908AM
1	Examin	er	4a. Facility Name (If not institution,		apita 1		4b. City, Town, or Ral Hin		City	4¢.	County of Dea	ın
			/	0 H () J /) Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24	4 Hrs. 8. Date of B	irth	9. Bir	thplace (State or Foreign
	Funeral Director		219-14-5635	1 X]M 2□F	8		Months Days	Hours	Min. (Month, D			nstown, PA
	p _	-	Usual Residence of Decedent		100 Cib	y, Town or Lo						10d. Inside City Limits
	arylar show		10a. State 10b. County				cation					1 ☐ Yes 2 Ă No
	28a-1	Director	WV Mineral 10e. Street and Number		Ri	dgeley	10f. Zip Code			10a. Citi	zen of What C	ountry?
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	death	Funeral	RD2, Box 650		edent Ever in U.	S. 13. V	Vas Decedent of H	ispanic Origi	n? (Specify Yes or N		14. Race - Am	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heelth and Menial Hygiene. Department of Heelth and Menial Hygiene. Integrate: I them 27 is marked other than "natural", or items 23a or 28a-f show many injury or other traumatic event, the Modical Examiner must be notified at once.	ğ	1 ☐ Never Married 2 🖾 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo d 1 ☐ Yes If Yes, Gi Year or D	2∭ No ive			Specify:	Puèrio Rican, etc.)		Black, Whi	
2-0	72 ho	ted	15. Decedent's (Specify only highest				lent's Usual Occupa		of working	16b. Ki	nd of Business	/industry
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Maryland	d be fi	ă	Louis Herbert St	•							oumamo,	
Ž	should nd Me mark imatic	၉	19a. Informant's Name/Relationship			19b. Mailir	ig Address (Street a		Mae McFer or Rural Route Num		r Town, State,	Zip Code)
Ma	nd 2 s lith ar 27 is r trau		Johns Hopkins Ho						reet, Balt			
re,	of Hee		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place	ca) _	Date	20c. Lo	cation - City o	Town, State
īmo	Page nent c		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State We	st Vir Osteo	natory or other place ginia Sch pathic Me	nool ed. 3	-10-2007	Lew	isburg,	WV
Baltimore,	permit. Departr Importu any inju		21. Signat to of Funeral Service U	Mnsee	Gond. (Robert	Tisk) 4	Name and Address est Virgi 00 N. Lee	ss of Facility Inia Sc St.	chool of C Lewisburg,	steo WV	pathic 24901	Medicine
			23a. Part Enter the disease, or c shock, or heart failure. List of	omp cations that	elach line.			g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	mysician /Medical	İ	disease or condition resulting in death)	Due to	(or as a conseq		ic tion					7 days
	Examiner			Due to	Hyperte							10 years
		Je	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(ur as a conseq	-						
	cate be executed physicien and i the burial-transit	Examiner	that initiated events	c								
90,	oe exe	EX	resulting in death) Last	Due to	(or as a conseq	uence of):						
8760,	cate b physic the b	dical	'	d								100 W = 10
9 X	certific ding p	/Me	IF FEMALE:	23c. If yes, ou	itcome of pregna	incy					23d. Date of de	alivery
Вох	death atten	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live	birth 2 ☐ Feta nant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	1			Month	Day Year
P.O.	t the c by the achec	hysi	9 Unknown	9□ Unkr	nown							
Records, F	The law requires that the death certific sie has been signed by the atlending p page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant condition	s contributing to d	death but not res	ulting in the u	nderlying cause give	en in Part I.		tobacco u Yes 2		to the cause of death? Probably 4 Unknown
00	sw require s been si	Siete							24a. Wa		24b. Were a	utopsy findings available completion of cause of
R	The law te has	E							per 1 Yes	opsy formed? 22 No	death?	
		BeC	25. Was case referred to medical examiner?					26. Place	of Death (Check only			
of V	Physician: this certific ral director,	유	1 ☐ Yes 2 📉 No			ER/Outpatier		4 🗀 (40)	sing Home 5 ☐ Re			ecify)
u C	ing P	iio	27. Manner of Death 1 ☐Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time o Injury	Wor		28d. Describe	how inju	y occurred	
sio	tend death tor: /	cat	2 Accident investiga 3 Suicide 6 Could no	ot ho	a ad Lainea. As h			Yes 2 □ N		(Stroot an	id Number or F	Rural Route Number,
Division	satter or Al	Certification;	4 ☐ Homicide determin	ned 286. Plac build	ing, etc. (Specil	y)	eet, factory, office		City or T	own, State)	nutal Froute Humber,
	To the Hospital or Attending Physically within 24 hours alter death. To the Funeral Director: After this completely filled in by the funeral di	Medical (29a. Certifier 1 Sectiving (Check only one) 2 Medical E	xaminer: On the I	a best of my his basis of examina nner stated.	wladga, deal ition and/or in	conducted at the tir vestigation, in my o	ne dale and pinion, death	plane, and one to the h occurred at the time	e causa(s) e, date and	d place, and du	es stated ue to the cause(s)
	ofthin ofthin	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	te signed (Mor	nth, Day, Year)
	- 3 - 3		Max	MO			RES	- 00	0	Mar	ch 9	2007
	- 5 - 0		30. Name and address of person w	MO no completed cau	use of death (Iter	n 23a) (Type,	Print) RES	- 00	0	Mar	ch 9	2007
, _	F 3 F 0		30. Name and address of person w Patrick Troy 31. Date filed (Month, Day, Year)	mo completed cau	use of death (Iter	m 23a) (Type,	Print) Opital 6	- 00 (00 No	o -4 wolfe she	Mar. et B	ch 9	2007 Marylan 21287

		1 = For Amend #23b&c Per State Registrar	tate of Maryland	7/ Hepa Cer	rtment of He	ealth and M Death	lental Hygi	ene g. No. 2	007	0952
		Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of Death
Physic		Milton	Eugene	T	ruxon		March	Day 10 200	Year	9:15 P ^M
/Medi Exami		4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Death	·iai oii	4c. County		J.13 I
LAGIIII	101	Heartland Health	Care Cente	er	Adelph	ni		Princ	e Ge	eorges
Funeral		Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			ace (State or Foreign
Director		213-22-4769 ^{1⊠ M}	^{2□ F} 78	Yrs.	World's Days	riours wiii.	01/10/			land
pu ,		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation				1/	Od. Inside City Limits
arylar show d at	ъ.		,	•					"	1 XYes 2 □ No
he M 28a-f otifii	Director	Maryland Prince G	eorges	Waldo	10f. Zip Code		10	g. Citizen of W	/hat Count	trv?
a or		2664 Pinewood Dr			1	0.1			mat ooun	.,,.
If ICL A I STOUSO be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral		Was Decedent Ever in U.S	S. 13. V	206 Vas Decedent of His		ecify Yes or No-	USA 14. Race	e - America	an Indian,
fter d r iten	F	1 Never Married Married	Armed Forces? 1 X Yes 2 No		Vas Decedent of His f Yes, specify Cubar		Rican, etc.)		k, White, e	
urs a al'', o Exan	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date 9 9 5 1 -	53	I∐Yes 2Å No	Specify:		Specify	Bla	CK
72 ho	Completed	15. Decedent's Educat (Specify only highest grade of	on	16a. Deced	lent's Usual Occupa	ition	ing 1	6b. Kind of Bu	siness/Ind	ustry
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yialla 212 buld be filed withi Mental Hygiene. arked other than	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Miadle, M		_	
Tallylalla 2 should be filed and Mental Hygi is marked other raumatic event, t	은	Elizah Bosle	<u> </u>	ruxon		Viola	-/ D /- M /		loore	
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s 1 and 3 f Health item 27 other tr		Vivian Truxon/ W. 20a. Method of Disposition	20h. P	lace of Dispo.	Pinewoo	i [Valdori Date 2	<u>Mary</u> Oc. Location -	Land City or To	
Pages Tent of I		1X Burial 2 ☐ Cremation 3 ☐ Rem	loval from State		natory or other place			_holto	nhar	m Marulan
		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service LicenSee	Ma.	Lyran 22	C VETER 8	ans: 3/2(s of Facility 1/2 a	0/2007	Cuerce	Iomo	m,Marylan
permit. Departit Importa any inju		1/1/20	191	2	0605 Agr	nuc 12800 Pá	ams run	erar r sco.Ma	rvla	PA and20608
100		23a. Part1. Enter the disease, or complicate	ions that cause the death			17.46				Approximate Interval Between Onset and Death
Physician	9.3	shock, or heart failure. List only one immediate Cause (Final	cause on each	tinl	ulman	100001 V	West			Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):	LINE OF THE	my a	WUJ!			
Examiner		Sequentially list conditions	Diabetes Me	llitus		J				
₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequ	ience of):						
ecute and trans	Examin	Cause (Disease or injury that initiated events c resulting in death) Last	Prid Stage Due to (or as a consequ		Disease					
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d							_	
w requires that the death certific been signed by the attending p should be detached for use as	hysician/Me	IF FEMALE: 23c.	If yes, outcome pf pregna	ncy				23d Dat	e of delive	erv
atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)			Mo		Day Year
the of	nysi	9 Unknown	9□Unknown							
s that ned t	by P	Part II Sther significant conditions contri	outing to death but not resu	ılting in the ur	nderlying cause give	n in Part I.	23e. Did tob	acco use conti	ribute to th	ne cause of death?
equire an sig		Diapelia	Tellytte	P			1 □ Ye	s 2□No	3 Prob	ably 4 Uakhown
aw re	plet	and Stan	Ilmal G	Usa	Al		24a. Was ar	24b. \	Vere auto	psy findings available npletion of cause of
The The ate has bage	Completed	- Jo	, 0 0				perform	ned? 🗸 🤇	death?	2 No
stan:	Be C	25. Was case referred to medical examiner?				26. Place of Deat				
hysic his ce	2	1 ☐ Yes 2 ☐ No		ER/Outpatien		4 Linux sing Ho	me 5 Reside			0
ing P	ü	27. Manner of Units 1 Units at 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe ho	w injury occurr	ed	
teath.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	OC- Disease timiums. At ho	me form atr		res 2 □ No	206 Lanation (Ct.	makamal Aliinik	- u - u Door	I Davida Musebaa
or A after of Direction by	Certification:	4 ☐ Homicide determined	 Place of injury - At ho building, etc. (Specify) 	()	eet, factory, office		28f. Location (Str City or Town		er or nura	r noute warmber,
spital lours neral		29a. Certifier 1 Certifying Physic	ian: To the best of my kno	wledge, deatl	n occurred at the tim	ne, date and place,	and due to the ca	use(s) and ma	inner as st	tated.
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Examine	r: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death occur	red at the time, da	ate and place,	and due to	the cause(s)
To the Complex	ğ	29b. Signature and title of certifier			29c. License	number	29	d. Date signe	d (Month,	Day, Year)
		1 m				6147		3/12/	07	<u> </u>
Dam	I.A.	30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Print)			1,1	- /	0
DDD	VIT	NASREEN KANGO. 31. Date filed (Month, Day, Year)	770/ CARR 32. Registar's Signa 2007	0/1/4v	e. IAKon	DA PARK	MARYLA	and 2	09/2	
St Regist	ate rar	MAR 1 3	2007 Mesur	K	Spect ,					
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of			giene 2	007	09523
			1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month		Year	3. Time of Death
	Physici /Medi		MIRIAM BEA	LL VERMII	LION			MARCH	9	2007	5:00 A M
	Examir		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Dea	ith	4c. Cou	nty of Death	
			708 Knoxville			Knoxv				ederic	
н	Funeral			6. Sex 7. Ag	e (In yrs. last birthday 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	1. (Month, Day	Year)	9. Birthr	place (State or Foreign ntry)
	Director		578-48-6714 Usual Residence of Decedent		72 Yrs.			July 3	1934	Wash	ington,D.C
	land wo		10a. State 10b. County		10c. City, Town or L	ocation				1	IOd. Inside City Limits
	Mary Fish	ţŏ	Md. Mont	gomery	Rockvi	lle					1 ☐ Yes 2 🛣 No
	128a	rec	10e. Street and Number			10f. Zip Code		1	l0g. Citizen	of What Cour	ntry?
	h with	D	4232 Landgreen	n Street		20853	3		Unit	ed Sta	tes
	within 72 hours after death with the Maryland ene. than "natural", or itama 23a or 28a-f show (a Mailcal Examinat mast be multime at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No-		Race - Americ	
9	or its	显	1 ☐ Never Married 2 ☐ Marrie		No	1 ☐ Yes 2 No	Specify:	itto Nicari, etc.)		Black, White,	White
g	ural',	d by	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:		10 103 2010	Specify.		3,00	cny.	
Maryland 21215-0036	"natu	Completed	15. Decedent' (Specify only highesi	s Education grade completed)	(Giv	edent's Usual Occup e kind of work done	during most of w	orking	16b. Kind o	f Business/In	dustry
2	withir sne. than	m du	Elementary/Secondary (0-12)	College (1-4or 5	(+)	DO NOT use retired egal Secre	•			Law	
N D	filed Hygie Sthar ant, II		17. Father's Name (First, Middle, L	ast)	116	gar secre		ame (First, Middle,			
an	d be antal rad o	Be.	Milton James				Mary	Wells			
<u></u>	2 should be and Mental is marked craumatic avi	2	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mail	ing Address (Street		Rural Route Number	r. City or Tox	wn. State. Zic	Code)
<u>\(\text{\text{S}}\)</u>	nd 2 lith a 27 is r trat		Jessica L. Shull	Lenbarger/Da		708 Knoxv					21758
<u>6</u>	s 1 a f Hea itam otha		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place	20)	Date	20c. Locatio	on - City or To	own, State
altimore,	Page ento nt: It ry or		1 ☐ Burial 2 🗷 Cremation 4 ☐ Donation 5 ☐ Other (Sp			Litan Cre		9/07	Alexa	ndria,	Va.
<u>=</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: It itam 27 is marked other than "natural", or itama 23a or 28a-f show amy injury or other traumatic avent. It a Marical Examiner must be nufficed at once.		21. Signature of Funeral Service L		-	2. Name and Addre Muriel H.					
ñ	E E E B		DX oy w.	Barrer	Str.	P. O. Bo	. вагрег ох 5038,	Laytonsv	rille,	Md. 2	0882
			23a. Part1. Enter se lisease, or o shock, or heart ailure. List o	complications that caused	the death. Do not en						Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	•	STATIC EN	OMETER AT.	CANCER				Onset and Death
	/Medical		resulting in death)	a	a consequence of):	JOHN TICTIN	CILICLIC				
	Examiner		Sequentially list conditions,	b							
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	and -trans	каш	that initiated events resulting in death) Last	C. Due to for an	a consequence of):						
8/60,	icate be executed physician and s the burial-transit	三田		Due 10 (01 as	a consequence on,						
ğ	phys phys the	dlcal		d							
Š Š	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				234	Date of delive	20/
ROX	seath atter for u	clar	in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			1	Month	Day Year
j.	the d by the ached	nysi	9 Unknown	9□ Unknown							
 J	es that igned b	by PI	Part II. Other significant condition	s contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?
ğ	v require been sig should b	ed to						1 □ Y	es 2 No	3 Prob	ably 4 Unknown
Vital Records,	aw requasi been 2 should	Completed						24a. Was a	in 24	b. Were auto	psy findings available
ř	The lay	mo						autops perform	med? 2 Z No	death?	mpletion of cause of 2□ No
<u>a</u>	i ician : Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of De	eath (Check only on		12,700	
010	.sb	ToE	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	int 2 ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing	Home 5 Reside	ence 6 🛣	Other <i>(Specif</i>	Daughter' Home
0			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28b. Time (of 28c. Injun World	y at k?	28d. Describe ho	ow injury occ	curred	
20	Attanding or death. ector: Afte by the fune	catl	2 Accident investig	ation		M 1 🗆	Yes 2 □ No				
DIVISION	l or Attanafter deatl	Certification;	3 Suicide 6 Could no 4 Homicide determine		ury - At home, farm, si c. (Specify)	reet, factory, office		28f. Location (Si City or Town		mber or Rura	I Route Number,
_			20-0-45					1			
	To tha Hospita within 24 hours To tha Funaral completely filled	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination and/or in	th occurred at the tin evestigation, in my o	ne, date and plac pinion, death occ	e, and due to the courred at the time, d	ause(s) and ate and plac	manner as s e, and due to	tated. the cause(s)
	To tha within To tha comple	Mec	29b. Signature and title of certifier	and manner sta	Med.	29c. Licens	e number	2	9d. Date sig	ned (Month,	Day, Year)
	F ≯ F 8		1/3-7/1	1/11		1 7 7 1	100			RCH 9,	
C	2		30. Name and address of person w	of completed cause of d	eath (Item 23a) (Type	Print)	170				
(C	D			DWARD, JR.,	/	416 OLAND	WOOD COU	RT, OLNEY	, MD.	2083	2
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	9 46					
	Registr	ar	MAR 12	2007	as the first	W					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Johanna Katherina Veres 9, March 2007 0550 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 15,1939 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Yrs. 215-66-4576 67 Director Germany Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2XXXNo Directo Maryland Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Misty Lane 21904 U.S.A. or Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other then "natural, or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nine Years Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is rr eny injury or other traum James Veres, Sr. (Husband) 14 Misty Lane, Port Deposit, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 03/14/07 4 □ Donation 5 □ Other (Specify) R.A. Ferris & Co., Inc. West Chester, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 attorney. W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) una **Physician** 5 months /Medical Due to (or as a co nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 1 PS 2 □ No Completed 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 🗆 Yes 20 No 2 A No 1 Yes : After this certifical funeral director, p To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann f Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation hours after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Irina Mikityanskaya, M.D., 501 South Union Avenue, Havre de Grace, MD

29c. License number

D0063042

29d. Date signed (Month, Day, Year)

7006

Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar	С	ertificate of D	Death		Reg	. No. 2	107	09525
	1. Decedent's Name (First, Middle, Last)				2	. Date of Death Month	Day	Year	3. Time of Death
in al	Stanley Weiland					March 8,	2007		2:05 рм
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location o	f Death		4c. Count	y of Death	
	3146 Gracefield Road #301			er Spr			Mont	tgomer	
	128-22-7919 1x M 2□F 83	yrs. last birthd Yrs	Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Y		Cor	place (State or Foreign intry) New York
	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town of	Location						10d. Inside City Limits
ŏ									1 x Yes 2 No
ect	Maryland Montgomery	Silve	er Spring 10f. Zip Code			100	. Citizen of	What Cou	intry?
Funeral Director	10e. Street and Number		· ·			109			y .
rai	3146 Gracefield Road #301		20904		-1-0 (01	f. Van an Na		.S.A.	ican Indian,
nne	11. Marital Status 12. Was Decedent Ever i Armed Forces?	n U.S.	 Was Decedent of His If Yes, specify Cuba 	n, Mexican	gin? (Speci i, Puerto Ri	can, etc.)		ack, White	
УF	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	10/6	1 ☐ Yes 2 No	Specify:			Speci	fy: Wi	ite
Be Completed by	3 ☑ Widowed 4 □ Divorced Year or Dates: 1944		andont's Usual Occupa	tion		16	b. Kind of E		N1-
ete	15. Decedent's Education (Specify only highest grade completed)	(G	ecedent's Usual Occupa iive kind of work done d fe. DO NOT use retired	uring most	t of working	,	D. KING OF L	Jusii less/ii	ildustry
d I	Elementary/Secondary (0-12) College (1-4or 5+)		· ·				A	erospa	ICO.
ပိ	47 Esthada Nama (Eint Middle Loct)	Aei	rospace Engine		r's Name /	First, Middle, Ma			ice
Be	17. Father's Name (First, Middle, Last)				,	, , ,	auen ouma	me	
2 L	Samuel Weiland	1			ora Dor				
	19a. Informant's Name/Relationship (Type. Print)	19b. M	alling Address (Street a	und Numbe	er or Rural i	Route Number, (City or Town	ı, State, Z	ip Code)
	Michael Weiland - Son		Stone Springs	Lane,					
	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	b. Place of Di cemetery,	sposition (Name of crematory or other plac	e) :	Dai	te 20	c. Location	- City or	Town, State
		udean Me	emorial Garden	ıs	3/9/20	07	Olney,	Mary1	and
	21. Signature of Euperal Sovice Licensee		22. Name and Addres			- T			
) SIRM		Hines-Rinaldi 11800 New Ham	. runer pshire	e Avenu	e, inc. e, Silver	Spring	g, Mar	yland 20904
	23a. Part1. Enter the disease, or complications that caused the cashock, or heart failure. List only one cause on each line.					_			Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) A. Metastati Due to (or as a condition pure to form the conditio		mall Cell Lung	g Cance	er				1 year
	Conventionly list conditions								
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):							
Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c								
Ĕ	resulting in death) Last Due to (or as a cor	nsequence of):							
cal									
edi									
N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pr		• ETE - 1 - 1				23d. D	ate of deli	very
cia	in the past 12 months? 1		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				N	1onth	Day Year
Completed by Physician/	9 ☐ Unknown 9 ☐ Unknown					·			
γ	Part II. Other significant conditions contributing to death but not	t resulting in th	ne underlying cause give	en in Part I		23e. Did toba	cco use co	ntribute to	the cause of death?
q p	Chronic Obstructive Pulmonary I	Disease				1 🗷 Yes	2 □ No	3□ Pr	obably 4 □Unknown
ete		0 11	1 Di			24a. Was an	24h	Were au	topsy findings available
ш	Hypertensive & Arterioscerotic	Cardiov	ascular bisea	se		autopsy		prior to death?	completion of cause of
ပ္ပ						1 Yes 2	X No	1 ☐ Yes	2 No
Be	25. Was case referred to medical examiner? Hospital:		etiont 3F DDA Othe	ar.		Check only one,			
P	1 ☐ tes 2 🕱 No	2 ER/Outpa	allerit 3 DDA	4 LINU		e 5 🗷 Residen			cify)
on:	1 Natural 5 □ Pending (Month, Day Yea		iry Worl			od. Describe nov	r injury occi	IIIeu	
cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury			Yes 2		N. I /Ot		- h D	Deute Number
THE STATE OF	4 Homicide determined 28e. Place of injury - building, etc. (St	At home, farm <i>becify)</i>	, street, factory, office		28	City or Town,	et and Nun State)	iber or Hi	ıral Route Number,
S			to the second second		- 1 - 1	and allows to the			-1-1-1
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner and manner stated.								
ž	9b. Signature and title of certifier	1	29c. Licenso	e number		29	d. Date sign	ned (Monti	h, Day, Year)
	James G. Br. Min.	CILL	D07	285			March	8, 20	007
	30. Name and address of person who completed cause of death	(Item 23a) (Tv	/pe, Print)						
	James A. Brown, M.D., 9707 Medica			e 300.	Rockv	ille, Mar	yland 2	20817	
te	31. Date filed (Month, Day, Year) Registrar's S		, ,				-		
ar	MAR 1 2 2007	A A	parte						

Sta Registrar

Please Type or Print in Black Indelible Ink. En	Ensure All Copies Are Legible
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		Please	Type or Print						egible.		
		For State	State of Ma	•	partment of h		-	-	TOOG	0050/	m
		Registrar			ertificate of	Death	2. Date of De	Reg. No.	1001	3. Time of Death)
Physicia	an	1. Decedent's Name (First, Middle, La Peter Douglas	Williams				Month	Day	Year		
/Medic	al	Peter Douglas 4a. Facility Name (If not institution, given			4h City Town	or Location of Death	March		ounty of Death	605 A [™]	
Examin	er	1321 Flag Harbor			St. Leon	_			lvert		
Funeral				(In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthr	place (State or Foreign	7
Director			1□M 2□F	30 Yrs	Months Days	Hours Min.	Feb 20	1977	Mary		
70		Usual Residence of Decedent									_
arylar show d at	_	10a. State 10b. County Maryland Calver		10c. City, Town or St. Leon						10d. Inside City Limits 1 ☐ Yes 2X No	
ne Ma 8a-f s	Director	-		DC. DCOI.				10- 011-	- (14# 1.0		_
vith th		10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?	
eath v	Funeral	1321 Flag Harbor	Blvd 12. Was Decedent E	verin IIS 1	20685 3. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sr	pecify Yes or No	Unit	ed Sta	tes an Indian.	_
ter de 'item	Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	0	If Yes, specify Cub	an, Mexican, Puerto	o Rican, etc.)		Black, White,	etc.	
urs af	by	3 ☐ Widowed 4 🙀 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		S	Specify: whi	te	
2 hou	Completed	15. Decedent's E (Specify only highest gr	Education	16a. De	cedent's Usual Occu	pation	kina	16b. Kind	of Business/In	dustry	
thin 7 e. an "r	Jple	Elementary/Secondary (0-12)	College (1-4or 5+	Tit	e. DO NOT use retire	ed)	Mily				
ed wi ygien ier th	Con	10		cont	ractor	T			structi	on	_
be filed within 72 hours after death with the Maryland tal Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Las				18. Mother's Nam	_ `		urname)		
ould Men narke	ဥ	Frederick Steven		1.0		Mary Dar					_
and 2 should ealth and Mer n 27 is marke er traumatic		19a. Informant's Name/Relationship Darlene Williams			ailing Address (Street						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	20a. Method of Disposition	- Rogers- II		sposition (Name of crematory or other pla		Date		ation - City or To		_
ages nt of t: If it		1 屎 Burial 2 □ Cremation 3 [1		1	2007		•		
artme artme ortan injur		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Central	Cemetery 22. Name and Addre	ess of Facility	2007	Bars	tow Mar	yıand	-
permi Depa Impo any ir once.		DRaw	\sim		22. Name and Address 4405 Broom	'Ra	usch Fu	neral	Home	20676	
STS.		23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused	the death. Do not	enter the mode of dy	ing, such as cardiac	or respiratory a	arrest,	oric "b	Approximate Interval Between	_
Physician		Immediate Cause (Final	/	1						Onset and Death	
/Medical		disease or condition resulting in death)	Contract of the Contract of th	nphom	14					years	-
Examiner			h								
ps. 09	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					- 1		
be executed cian and burial-transit	Examiner	Cause (Disease or injury that initiated events	c								
be exe ician a burial-i		resulting in death) Last	Due to (or as a	consequence of):					}		
ate b	dica		d								_
sertific ding p	/Me	IF FEMALE:	23c. If yes, outcome p	of pregnancy					1 5 - 1 - 1 - 1 - 1 - 1		
attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal death	3 ☐ Ectopic pregnand	СУ		23	3d. Date of deliv Month	ery Day Year	
the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	unie or death	omer (apecity)						
that led by deta	by Physician/Medical	Part II. Other significant conditions	contributing to death but	t not resulting in th	e underlying cause gi	ven in Part I.	23e. Did	tobacco us	e contribute to t	the cause of death?	
puires r sign lld be	d b						1 🗆	Yes 2□	No 3 ☐ Pro	bably 4 Unknown	1
w rec s beer shou	Completed						24a. Was	s an	24b. Were auto	opsy findings available empletion of cause of	3
he la e has age 2	шc						auto	psy ormed? 2 No	death?		
an; T tificat tor, pa		25. Was case referred to medical				26. Place of Dea			T ☐ Yes	2 □ No	-
ysicia is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpa	tient 3 DOA Ot	hor:	ome 5 🐧 Res		☐Other (Speci	fy)	
ig Ph ter th neral	L:U	27. Manner of Death	28a. Date of Injury (Month, Day)	y 28b. Tim Year) Inju		iry at	28d. Describe	how injury	occurred		
endir ath. or: Af	atio	1 Natural 5 Pending 2 Accident investigation	on	,]Yes 2□No					
ir Atte ter de irecte irecte	Certification:	3 Suicide 6 Could not I 4 Homicide determined		ry - At home, farm . <i>(Specify)</i>	street, factory, office		28f. Location ((Street and wn, State)	Number or Run	al Route Number,	
oital o urs afi ural D				, ,	- 0						
To the Hospital or Attending Physician; The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the I	Medical		Physician: To the best of aminer: On the basis of and manner stat	examination and/o							
To th withir To th comp	Me	29b. Signature and title of certifier	0.0			se number	,	29d. Date	signed (Month,	Day, Year)	
		ration	file			5906	/	Marc	h 9 20	07	_
4		30. Name and address of person who A Patel MD 110				k MD 2067	8	_			

State Registrar

31. Date filed (Month, Day, Year)

9 2007 Registry's Signature

		Í	For State Registrar	State o	f Marylan		artment of H			giene Reg. No.	07	09527	
	4	S.F	1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath		3. Time of Death	_
	Physici		Raymond Ry1	and W	e1ch				Month March	9, 200	Year 17	5:10 A M	
	/Medio	1.0	4a. Facility Name (If not institution				4b. City, Town, or	Location of Dea			ty of Death	13.10 H	_
			Garrett County	Memorial	Hospit	al	0ak1an	d		Ga	rrett		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hr		th	9. Birth	place (State or Foreign	Т
1	Director		220-20-5931	1 🕅 M 2□ F	79	Yrs.	Months Days	Hours Mir	June 12	1927	Mary	land	
	P.		Usual Residence of Decedent										_
	show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
	Be-f	ct		rrett			0akland					1 ☐ Yes 2 📉 No	_
	라 다 다 C	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen o		ntry?	
	72 hours after death with the Maryland natural", or Iteme 23a or 28e-1 show iteal Examiner must be notified at	Funeral Director	616 Norris Wel					550		US			
	or de	nne	11. Marital Status	Armed Fo	edent Ever in U prces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (n, Mexican, Pue	Specify Yes or No into Rican, etc.)	- 14. R	ace - Ameri lack, White,		
36	or i	by F	1 ☐ Never Married 2 🛣 Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	ve _		1 ☐ Yes 2 TNo	Specify:		Spec	ify: T.T	1. 4 4 0	
5-0036	hour tural	d b		Year or D	ates: WWI	-	tastia Usual Ossus	-Ai		10 Kind of		hite	_
<u>.</u>	n 72 nai	Completed	15. Decedent (Specify only highes			(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of w	orking	16b. Kind of	Business/in	laustry	
2121	withi ene than	m	Elementary/Secondary (0-12)	College (1-4or 5+)		intendent	•		Conito	+ion i	District	
2	be filed within 72 hours after death with the Marylan tal hygiene. Id other than "natural", or iteme 23a or 28e-f show event. The Madical Examiner must be notitied at		17. Father's Name (First, Middle,	Last)		buper.	LITCEIIGEIIC		ame (First, Middle,			DISTITUT	
Maryland	should be ind Mental marked o	To Be	Norris K.	Welch				Arti	e M.	Fr	iend		
₹	2 should be and Menta is marked eumatic ev	F	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street a					Code)	
Σ	d 2 street		Ruthann Welch/				Norris We						ľ
ā,	s 1 and 2 should if Health and Men tiem 27 is marke other treumatic		20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date	20c. Location			
altimore,	permit. Pages Department of Important: If it sny injury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	_	natory or other plac D. Mem. G	ì	11/07	0aklan	d Ma	wirl and	
₹	artme prtan ortan injury	1	21. Signature of Funeral Service	100	Gal		. Name and Addres						
g	permit. Departi		1 RIVI	I Thomas			tewart Fu			S. Seco Land, M			
	• 3/		23a. Part1. Enter the disease, or	complications that	aused the deat						агута	Approximate	_
			shock, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.	/	i/	4				Interval Between Onset and Death	
1	Physician /Medical		disease or condition resulting in death)	a	ungen	41 mg	Mec	v 4	91/4	· · · · · · · · · · · · · · · · · · ·		345	_
ı	Examiner			Due to	gras a conseq	uence of:	TIL	1 1	a . /			1 1.11	
89		-	Sequentially list conditions, if any, leading to immediate	b. Due to	Carasa conseq	uence of):	14	a 0 1/2		Λ		(WC	
	ted	in in	Cause (Disease or injury	(14hee	- 1	tin (audisu	noli	1/5.			
	xecu and	Examiner	that initiated events resulting in death) Last	c	(or as a conseq	uence of):		40 000	carde .				-
8760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cai E											
89	ficate p phy is the			0.			V 1.000						
Box	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna					23d. [Date of delive	erv	
ň	leath atte	ciai	in the past 12 months?		oirth 2∏Feta nant at time of d		Ectopic pregnancy Other (specify)				Month	Day Year	1
o.	at the de by the a	ıysı	9 Unknown	9□ Unkn	own								
J.	res that igned to be deta	by PI	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use co	ntribute to t	he cause of death?	
Vital Records,	quires n sign	Q D							10	Yes 2□No	3 🗌 Prob	oably 4 Kinknown	1
<u>ဂ</u>	w require been signature	Completed							24a. Was	an 24t	. Were auto	opsy findings available	
Ä	The la	E							autop	rmed?	death?	opsy findings available impletion of cause of	
æ		CO	25. Was case referred to medical					00 81	1 Yes	2 00	1 🗆 Yes	2 □ No	_
	or Attending Physician: ther death. Director: Atter this certific in by the funeral director,	To B	examiner?	Hospital:	npatient 2	ER/Outpatien	t all DOA Othe	25	eath (Check only only only only only only only only		thor /Coast	6.1	-
Ö	g Phys er this eral di		27. Manner of Death		of Injury th, Day Year)	28b. Time of			28d. Describe			y)	+
<u></u>	nding F tth. : After e funer	tio	1 Accident 5 Pendin investig	9	th, Day Year)	Injury		(? Yes 2 ☐ No					
Division of	ol or Attendi after death. I Director: A d in by the fu	fice	3 ☐ Suicide 6 ☐ Could r	inad 286. Flace	of Injury - At he	ome, farm, str	eet, factory, office		28f. Location (Street and Nur	nber or Rura	al Route Number,	-
5	el or s afte il Dir	Certification:	4 Homicide	build	ng, etc. (Specif	y)			City or Tox	wn, State)			
	To the Hospitel within 24 hours a To the Funeral I completely filled		29a. Certifier Certifyin	g Physician: To the	best of my kno	wledge, death	occurred at the tim	e, date and plac	ce, and due to the	cause(s) and	nanner as s	stated.	-
	in 24 he Fi he Fi	Medicai	(Check only 2 Medical one)	Examiner: On the b and man	asis of examina ner stated.	uon and/or in	vestigation, in my of	oinion, death occ	curred at the time,	date and place	e, and due to	o the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of pertifier	1			29c. License			29d. Date sign	•		-
}			(A/				D23	979			3/9/07	7	
	ι Λ		30. Name and address of person	who completed caus	se of death (Iten	n 23a) (Type,	Print)						
	641114		Dr. Robert Gora	alski, MD	211 N	N. Four	th St.,	Dakland	Marylan	d 215	50		
(A)	Sta		31. Date filed (Month, Da	1 2 2007	egistræ's Signa	ature A	Acade a						
	Registr	ar			A CONTRACTOR OF	7	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 11, 2007 Year Physician Juanita F. Wheeler 7:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Of Waldorf Waldorf Charles If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 0Ct. 16, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2🗡 F 220-22-5820 Kentucky 85 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 🕅 No Charles Maryland Waldorf Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4140 Old Washington Road 20603 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baker Grocery Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nelson Fields Pearl M. Dutv ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Mote/Daughter 8335 Oliver Shop Road, La Plata, Maryland, 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Huntt Crematory 03/12/2007 Waldorf, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road M01246 Huntt Funeral Home Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final TR Physician DIO en disease or condition resulting in death) /Medical Due to (or as a consequence of), Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing 23e. Did tobacco use contribute to the cause of death? Completed by 1 TYes 2 No 3 Probably 4 Sthknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has b rector, page 2 s 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: The law requires that the death certificate be executed s after dea.
rai Director: After filled in by Hospital within 24 hours a completely

Certification: 4 Homicide 29a. Certifier Medical (Check only one)

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

huin 1 32. Redistrar's Signature 3 Date filed (Month, Day, Year)

MAR 1

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Daphne Annette		L. For State		te of Maryla	Ċ.	artificata.			Menta	al Hyg		- u- (0.00	~ ~ ~ ~ ~
Physicia	n/	Registrar 1. Decedent's Name	(First, Middle,	Last) Danhne	Annette	Wade				2	. Date of Dea			3. Time of Death
Medical Examir	er	DAPHNE		A.		WADE					Month March 10	, 2007	fear	1330 hrs
(4a. Facility Name (if 7823 Citade		give street and no	ımber)		4b. City, To Sever		ocation of	Death		4c. Count	ty of Deat A rund el	
Europal	4	5. Social Security N		. Sex	7 Age (In vrs	. last birthday)	<u></u>	1 Year	If Under	24Hrs.	8. Date of Bi			rthplace (State or
Funeral Director	1	577-78-71		1 M 2 K	47		Months	_		Min.		25 1959		gn WASHINGTON
	ŀ	Usual Residence of		I M 2 F			15.		1					DC DC
any	İ		10b. County		10c. Ci	ty, Town or Lo								10d. Inside City Limits
and I show	٥	MD	ANNE A	RUNDEL		SEVE								1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nur 7823 CI		RIVE			10f. Zip					10g. Citizen of V	What Cou	intry?
with t		11. Marital Status	-77		cedent Ever in						cify Yes or N			rican Indian, Black,
death or iten	Funeral	1 Never Marrie	ed 2 X Man	1 A Yes	2 No		f Yes, specify	_		Puerto R	ican, etc.)		hite, etc.	
s after	2	3 Widowed		ced If Yes, Give Ye or Dates:		1	Yes 2				al. dono		y BLA	
hours		15. Decedent's Ed Elementary/Seco			de completed) 1-4 or 5+)		lent's Usual (most of wor					16b. Kind of	Business	/industry
36 Ihin 72 than	Completed	Elomontal y/ 0000	11001) (0 12)	2		DOM	ESTIC	ENG	INEER			PR	IVAT	E
5-0036 led within 7 Hygiene. other than	5	17. Father's Name (First, Middle, L								First, Middle,	Maiden Surnar	me)	
2121; Muld be fil Mental F marked c event, i	Be	SAMUEL P				_				RIE	J.	TOLSON		
D 2: shoulk and M 7 is m:	입	19a. Informant's Na				2.0						mber, City or T MARYLAN		- 17
and 2 sho ealth and tem 27 is traumat	ŀ	MARVIN . 20a. Method of Disp		/HUSBAND		b. Place of Disp					Date .			r Town, State
Baltimore, permit. Pages I an Department of He. Important: If ite		1 X Burial 2					other place)	CONTA-	,	2/20)/2007	ADITM	CTON	, VIRGINIA
Itim nit. Pa artmer ortan	-	4 Donation 5 21. Signature of Full			A.	RLINGTO	N NA1.							RAL HOME
Dept. Dept.	d	K.). M	1-ha	l l		7474	LAND	OVER			OVER, M		
Physician		23a. Part I. Enter th	e disease, or o	omplications that	caused the dea	ath. Do not ente	er the mode o	f dying,	such as ca	rdiac or	respiratory a	rrest, shock, or	heart	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease	a Subdura	1 hemorr	hopes as	sociate	l wit	h acut	e and	l chroni	c alcohol	lism	Death
,=	- 1	or condition resulting	ig in death)	Due to (or as	a consequence	e of):								
	iner	Sequentially list con if any, leading to im- cause. Enter Unde	mediate rlying Cause	-	a consequence	e of):								
ted Insit	Examiner	(Disease or injury the events resulting in			a consequence	e of):								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	edical	X UNPENDED		X AMENDED	,27,28a	f, perME	.g867.	5/10/0	07 TT					
6876C certificate nding phys	ΣI	IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes,	, outcome of pr	regnancy	Fetal death	3		pregnan	ICV	23d. Date Month	e of delive	ery Day Year
x 68 h certii tendin	- 75 I	past 12 months	?	4 Preg	nant at time of	5	Other (Spe			program	icy.	I I I I I I I I I I I I I I I I I I I		Day 100
Box te death of the attented for us	Physic	1 Yes 2 N		g Unkr	nown						I aa Bii			the second of the tho
ision of Vital Records, P.O. Box 6876. Attending Physician: The law requires that the death certificate reath. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the by the funeral director, page 2 should be detached for use as the by	by P	Part II. Other signi	ficant conditio	ons contributing	to death but no	ot resulting in th	ie underlying	cause g	iven in Pa	rt I.		-	restants.	o the cause of death?
ls, F quires en sign				<u>.</u>							24a. Wa			autopsy findings available
COFC	Completed	<u> </u>									auto	opsy formed?		completion of cause of
tal Recidins: The certificate	9							00 Di	· (D · · · · · ·	01	1 🗸 Yes	2 N	1 🗸 `	Yes 2 No
ician:	Be	25. Was case reference examiner?		Hospital:	Inpatient 2	ER/Outpati			of Death (Home 5	Residence	6 🗸 Oth	er: Scene
n of Vital Records, ding Physician: The law requii After this certificate has been s funeral director, page 2 should	£	1 ✓ Yes 27. Manner of Deat	2 No	28a. Date	e of Injury	28b. Time		•	y at Work			e how injury occ	لتقدا	
ion (tending eath.	tion	1 Natural	5 Pendi	ng Fnd 3	th, Day,Year) 3/10/2007	Fnd 1:	20 mm	1 Y	es 2 X	No s	subject	fell at h	nome	
Division tal or Attendi rs after death. al Director: A	ertification:	2 X Accident 3 Suicide		I Qali UII		t home, farm, s		office b	uilding, et	: :	28f. Location or Town,		ımber or F	Rural Route Number, City
Division spital or At hours after dineral Direct y filled in by	Cert	4 Homicide	deterr		house							adel Dr.	Sever	n, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical (29a. Certifier 1 (Check only one) 2	Certifying Phy Medical Exam	ysician: To the be niner:On the basis	of examination	ledge, death oo n and/or invest	curred at the igation, in my	time, da opinion	ate and pla , death oc	ce, and o	due to the ca the time, dat	use(s) and man te and place, ar	ner as stand due to	ated. the cause(s)
To with	Med	29b. Signature and	title of certifier	and manner	stated.		290	. Licens	e number			29d. Date s	signed (N	fonth, Day, Year)
		VI mus	nit A	re Uha	el.			0.0.1	M.E.			March 1	1, 2007	7
		30. Name and addr		who completed car	use of death (It									
IR		Margarita K		Assistant Me			Penn Sti	eet, Ba	altimore	, MD 2	1201			
St Regist		31. Date filed (Mon	th, Day Year)	Sac. F	Registrar's Sign	nature	ý							

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

		1 - State Registrar	tate of Marylan		artment of H tificate of L			ene 2007	09530
	å. %.	Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
Physic /Med		Jack	Worthingto	on			March 1	2, 2007	4:25 a M
Exami		4a. Facility Name (If not institution, give stree			**	Location of Death		4c. County of Death	
Tana.	48	147 Farmington R	oad West 7. Age (In yrs.)	last hirthday)	Accoke		8. Date of Birth	Prince	George
Funeral Director		407-01-7496		Yrs.	Months Days	Hours Min.	Jan. 16,	ear) Cou	un <i>try)</i>
TO		Usual Residence of Decedent		~			•		404 1-14- 00-11-14
anylar show	7	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 3€☐ No
the M	Directo	Maryland Prince Geor	rge Ac	ccokeek	10f. Zip Code		100	. Citizen of What Co	
3a or	<u></u>	147 Farmington Road V	West		20607			J.S.A.	
death	Funeral	11 Marital Status 12. V	Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spanic Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Exaction or marker notified at		1 Never Married 2 X Married	l □Yes 2. □No f Yes, Give		1 □ Yes 2 ₩ No	Specify:	1110411, 010.)	Specify: Whi	
5-0036 72 hours af natural; or	ed by	3 Widowed 4 Divorced 15. Decedent's Education	Year or Dates:		dent's Usual Occupa	ation	16	b. Kind of Business/l	
C 2 2 4	Completed	(Specify only highest grade co	mpleted)	(Give	kind of work done of DO NOT use retired,	luring most of work	ing	b. King of Business	riduotry
d 21215- fited within 72 Hygiene. ont, the Medic	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Qualit	y Contro	l Analyst	τ	J.S. Gover	nment
al Hyg	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
arytand 2 should be filed v and Mental Hygie marked other i umatic event, tr	2	Unknown				Kate		nington	
re, Maryland 2121. I and 2 should be filed within Health and Mental Hygiene. Item 27 Is marked other than " other traumatic event, tra Mar	1	19a. Informant's Name/Relationship (Type,	Mife					city or Town, State, 2 seek, Md.	
e, and teal	1 1	Alva Worthington 20a. Method of Disposition	005 0	Mana of Diago	-iai (A)		2010	c. Location - City or	
Pages ent of nt: If it		1 ☐ Burial 2 【XCremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	tropoli	istion (<i>Name or</i> natory or other plac itan Fune:	"March 13 ral Servi	3, 2007 .ce z	levandria	, Virginia
Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or othe once.		21. Signature of Funeral Service Licenses		22	. Name and Addres	s of Facility	. D 7		i 123
m 40540		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications of the complete Cause (Final Inc.).	M0066	58 S	1270 Hawt	horne Rd.	, Indian	Head, Md.	20640 Approximate
***		shock, or heart failure. List only one c	ause on each line.	n. Do not ent	er the mode or dying	g, such as cardiac	or respiratory arres		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	o-scee	wonc a	12/10V	Ascul An	CERSA18	years
Examiner		1.	Due to (or as a conseq	derice ory.					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
18760, icate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a conseq	uonco of):					
8760, cate be ex chysicien a			Due to (or as a conseq	derice orj.					
	edical	d							
Box 6 eath certific ettending p	N/M	IF FEMALE: 23c.	If yes, outcome of pregna		75 -ti			23d. Date of deli	ivery
death death	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
p.O. I	Phys	9 Duknown					OZa Didasha	cco use contribute to	the course of death?
Records, P.O. Box 6 The law requires that the death certifi the has been signed by the ettending, age 2 should be detached for use as	þ.	Part II. Other significant conditions contrib	uting to death but not res	uiting in the u	nderlying cause give	en in Paπ I.	1 Yes	_/	obably 4 []Unknown
Records, he taw requires t e has been signe age 2 should be	etec						24a. Was an		Itopsy findings available
Rec he taw he saw ge 2 s	Completed						autopsy performe	prior to death?	completion of cause of
	CO	25. Was case referred to medicat				26 Place of Deat	1 Yes 20 h (Check only one)		2 No
- × v 0	To B	examiner? 1 Yes 2 No Hosp	nital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	or		ce 6 Other (Spe	cify)
Vision of Vita Attending Phyeician: or death. ector: After this certifics by the funeral director, I		27. Manner of Death 2 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	k?	28d. Describe how	injury occurred	
SiO tendi feath. tor: A the fu	catl	2 Accident investigation				Yes 2 □No	29f Location /Stro	et and Number or Ru	real Pouts Mumber
Division of l or Attending Phyratter death. Director: After this I in by the funeral di	Certification:	4 Homicide determined	8e. Place of Injury - At h building, etc. (Specil		reet, factory, office		City or Town,		irai noute ivuinber,
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Examiner	an: To the best of my kno	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau	se(s) and manner as e and place, and due	stated. to the cause(s)
To the P within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner stated.		29c Licens			d. Date signed (Monti	
7 <u>¥ ₹</u> 8		1			X	19431		3/12/10-	2
(30 Name and address of person who comp	leted cause of death (Iter	п 23a) (Туре,	Print)	4.	2 /	1.5	
DBIN		Track to pagami	11701 4	1 Minte	1201/6	LF/CB T	T. Ulphi	W/DIMO	20144
Control of the Contro	tate	31. Date filed (Month, Day, Year) MAR 1 3 20	32. Redstrar's Signa 07	ature	1				
Regis	trar	1 0 ZC	The state of the s	No 1	60348				

			1 - For State of Mar	-	artment of H			7111	7 09531
			Decedent's Name (First, Middle, Last)		Timouto or I		2. Date of Deat	ng. No.	3. Time of Death
	Physici		Eunice H. Williams				Month	,	ear M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death	March	12 200 4c. County of	
	ZXIIIII		Longview Nursing Home		Man	chester		Car	rroll
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		245-46-1275 1□M 2□X	7.2 Yrs.	Months Days	Hours Miss.	Sept 6		NC
	pu ,		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo					1011-11-01-11-1
	anyla ehov	2							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	8a-f	ectc	MD Carroll	Manche					
	with the	by Funeral Director	10e. Street and Number		10f. Zip Code	4.00	10	Og. Citizen of Wh	at Country?
	e 23	Frai	3332 Main Street	10.11.0		102	aif. Van aa Na	USA	American Indian
	He de	in.	11. Marital Status 12. Was Decedent Examed Forces? 1 □ Never Married 2 □ Warried 1 □ Yes 2 □ X Narried	Verin 0.5. 13.	was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	Rican, etc.)		American Indian, White, etc.
36	irs af	by F	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	,	1 □ Yes 2 □ X o	Specity:		Specify:	White
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or Iteme 23e or 28e-1 ehow to Medical Exeminer must be notified at	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation	11:	16b. Kind of Busir	ness/Industry
215	7 uid	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	kind of work done of DO NOT use retired	during most of worki f)	ng	Super 1	Fresh
21	d with giene.	E O	1 2	<u></u>	Cashie	r		Food S	tore
	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
<u>la</u>	Mental Mental arked c	5	Robert Wilson			Edna (Chapell		
Maryland	2 sho and I		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	l Route Number,	City or Town, Sta	ate, Zip Code)
	and in 27 m 27		Ted A. Williams/husband			a Ave We	estmins	ter, M	D 21158
ore	of H of H if Ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other plac	3/15	/2007 ²	20c. Location - Ci	ty or Town, State
Ĕ	mit. Pages entment of ortant: If It injury or o		4 □Donation 5 □ Other (Specify)	Carroll	Cremat	ion, Inc	Н	ampste	ad, MD
Baltimore	permit. Pag Depertment Important: I any njury o		21. Signature of Funeral Service Licensee	22	Name and Address			-	•
_	20 = 9		THE K ALO						
			23a. Phr 1. Enter the disease, or compil ations that caused the shock, or heart failure. List only one cause on each line	ne death. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	when hi	tun - 5	Leine	1		Onset and Death
7	/Medical		resulting in death) Due to (or as a	consequence of):		11			1
4	Examiner		Sequentially list conditions b	beatin	s of 1	may He	ypes S	imply	40 mg
	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	0			0	
	ecute and trans	cam	that initiated events .						
760,	te be executed ysicien and ie burial-transit		Due to (or as a	consequence of):					
687	- × 6	dicai	d						
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23c. If yes, outcome of	orogenaesy.					
Вох	atten for us	ian	in the past 12 months?	Fetel death 3	Ectopic pregnancy			23d. Date of Month	
o.	the d	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	ine or death 3L	Other (specify)				
Δ.	that the by detail		Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?
Records,	sign Id be	d by			, ,		1 □ Ye	s 2 No 3	☐ Probably 4 ☐ Unknown
Ö	w requir been si should	ete					24a. Was ar	245 1440	an autonou findinou unalekto
Re	has ge 2	Completed					autopsy periorn	/ prio	re autopsy findings available or to completion of cause of th?
a	- ×						1 ☐ Yes 2	ENO 1	Yes 2□ No
Vital	Physician: this certificanal director,	9 Be	25. Was case referred to medical examiner? 1. Voc. 2. No.	a 🗆 50/0	Othi	26. Place of Death			
o	ding Physician: h. After this certific funeral director,	2	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	28b. Time o	I 3LI DUA	4 Mursing Hor		nce 6 Other	(Specify)
O	ding I th. : After : funer	후	1 Natural 5 Pending (Month, Day 1 2 Accident investigation	Year) Injury	Work	k? Yes 2 □No		, , , , , , , , , , , , , , , , , , , ,	
Division	or Attendi efter death. Director: A in by the fu	#ica	3 Suicide 6 Could not be determined 28e. Place of Injury	/ - At home, farm, str	eet, factory, office		28f. Location (Str	reet and Number	or Rural Route Number,
á	al or Blind Direction	Certification:	4 Homicide determined building, etc.	(Specify)	·		City or Town	, State)	
	papita hours inera y fille		29a. Certifier 1 Certifying Physician: To the best of	my knowledge, deat	h occurred at the tim	ne, date and place, a	and due to the ca	use(s) and mann	er as stated,
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funeral	Medicai	(Check only one) 2 Medical Examiner: On the basis of e and manner state	xamination and/or in ed.	vestigation, in my op	pinion, death occurre	ed at the time, da	ite and place, and	due to the cause(s)
	To the composition	Σ	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Month, Day, Year)
	WIL		2 m W. (hadelle	the my	Do	25443		21/21	2007
-	NI		30. Name a / address of person completed cause of dea	ith (Item 23a) (Type,	Print)	011	-	1	
	\	. 4	John W. Mideleton r	nD 68	8 roole	Rd, V	Vistm	m Stes.	MD 2457
	Sta		31. Date filed (Month, Day, Year) 32. Registrar	s Signature					-,0/
	Registi	ar	MAR 1 3 2007	was IK	Societ &				

DHMH 17 Rev 1/2001

ORIGINAL

			Please T	ype or Prir							-		_		
			For	State of Ma	aryland	-				nd Men	ıtal Hy	giene	9		
			State Registrar			Ce	rtifica	te of	Death			Reg. No	200	-7	09532
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Y 3 7 20											ır	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	street and number)	NA	pior		. Town, o	r Location of D		_5	40	. County of De		743
<i>)</i>	Examin	er	Coacil I Hacoca A	مملا لم	10	Ke.	50	lik	bury	i			Vicor		
	Funeral		5. Social Security Number 6. Sec		e (Iri yrs. la		If Unde Months	r 1 Year Days	If Under 24		Date of Birt Month, Da	th v. Year	9. E		e (State or Foreign
	Director		154-18-1418	M 2 ∑ F	85	Yrs.		Juje			1/12/				Jersey
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation							10d.	Inside City Limits
	a-f sh filed	tor	Maryland Wicomic	:0	Sa.	lisbu	cv								1 X Yes 2 No
	ith the or 28	Director	10e. Street and Number					p Code				10g. Ci	tizen of What	Country'	?
	of within 72 hours after death with the Maryland sjere. Than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	rall	503 Schumaker Lane			140		2180		0.40			USA		ladiaa
	ter de items iner π	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ▼ N		. 13.	Was Dece If Yes, spe	edent of Hecify Cuba	ispanic Origin an, Mexican, F	1? (Specify Puerto Rica	Yes or No in, etc.)	-	14. Race - Ar Black, W		
936	ursaf al'', or Exami	by	3 ☑ Widowed 4 ☐ Divorced			1 Tes	2 K No	Specify:				Specify:	whi	ite	
5-0036	72 ho natur iical E	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	edent's Usu	al Occup	ation during most o	f working		16b. K	and of Busines	ss/Indus	try	
2	/ithin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5	i+)				during most of d)						
12 p	e filed within al Hygiene. other than " vent, the Mec	Co	12 17. Father's Name (<i>First, Middle, Last</i>)	_		Sec	creta	ry	18. Mother's	Name (Fil	rst, Middle.		Surance	_Con	pany
<u>a</u>	ould be t Mental arked or atic eve	To Be	Charles John Hoy	t						garet			,		
Maryland	2 should and Men Is marke aumatic	۱	19a. Informant's Name/Relationship (Ty	oe. Print)		19b. Maili	ing Addres	s (Street					or Town, State	e, Zip Co	ide)
	r z g g		Laura E. Riggin/	niece	_,						lisbu	ry,	MD 218	04	
ore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	1	ace of Dispo metery, cre				Date		20c. L	ocation - City	or Town	, State
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify)		Sal	isbur				/9/07			alisbu		
Ra	permi Depar Impor any ir once,		21. Signature of Funaral Service Licens	ee	~~~	_ 2	2 HOLI 501	oway Spow	s funer Hill	al Ho	me Pr	ofe	ssiona y, MD 2	l As	sociation
			23a. Part1. Enter the disease, or compli	cation that caused	CFS the death.	-							у, нь а		pproximate terval Between
	Physician		shock, or heart failure. List only or immediate Cause (Final	ne cause on each lir	ne	.11								In O	terval Between nset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as	a conseque	ence of):)	-							
	Examiner		Sequentially list conditions												
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a conseque	ence of):									
_E	oe executed cian and ourial-transit	xan	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):	·								
~	ficate be e I physiciar is the buri		L,	I											
289		Physician/Medical												20 =	
ROX	eath cert attending for use a	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy									delivery Da	y Year		
oj.	at the dea by the ai tached fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregna⊓t at 9⊡Unknow⊓	time of dea	ath 5[Other (s	pecify) _					Month	Da	y Teal
Į.	that the ed by detac		Part II. Other significant conditions con	ntributing to death b	ut not resul	ting in the u	underlying	cause giv	en in Part I.		23e. Did to	obacco	use contribute	to the c	ause of death?
Vital Records,	w requires that s been signed to should be deta	d by	1-12 herner's	Dzs	REDR					_	1 🗆 '	Yes 2	3□	Probabl	y 4 🗌 Unknown
<u>o</u>	aw rec s been	olete									24a. Was		24b. Were	autopsy	findings available
Ĭ	sician : The law certificate has t irector, page 2 s	Completed							-	_	autor perfo	psy rmed? No	death	?	etion of cause of
Ta I	sian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?						26. Place of	f Death <i>(Cl</i>		/			
<u>o</u>	Physic this or	ို	1 ☐ Yes No	lospital:		R/Outpatie			4 L Nursi				6 □Other (S	pecify)	
UC C	ding I	ion:	27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Day		28b. Time o Injury	of M	28c. Injur Wor	yat k? Yes 2 ⊟ No		Describe I	how inju	ry occurred		
DIVISION	Attendi death. ctor: A y the fu	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju	iry - At hon	ne, farm, st		-	163 2 140	28f.	Location (5	ation (Street and Number or Rural Route Number,			
2	al or / s after il Dire	Certification:	4 Homicide determined	building, etc	c. (Specify)						City or Tou	wn, Stat	e)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Exami	sician: To the best	of my know	rledge, dear	th occurre	d at the tir	me, date and	place, and	due to the	cause(s	and manner	as state	ed.
	To the H within 24 To the F complete	Medical	one)	and manner sta	ated.				e number						
	5	-	29b. Signature and title of certifier	1/1/	10.01	\cap	28	-		X		290. Da	ate signed (Mo	ontn, Day	7, rear)
,	Duel		30. Name and address of person who co	mpleted cause of	eeth (Item	23a) (Tyne	. Print)		262	18			1-1	_ /	
1	MAK		David E. Conall	NO Con	Hal F	LSDI	e A	BO	x 173	33	Solis	4.	MA	2	1802
	Sta		31. Date filed (Morth App. Year) 2	07 32 egistra	ar's Signati	Te /	sant!	,)			
÷.	Registr	ar		1		May	The state of the s								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** lartha 0 0 0400 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Salisbury 100m1 Coastal Hospice
5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/26/1949 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 F Delaware 220-52-9142 57 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 □ No Director Wicomico Maryland Salisbury 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7535 Titlest Drive 21801 USA items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after of tealth and Mental Hygiene. m 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No white Specify \$ 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barrett Business 12 Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Usilla Edna Oakes George Asbury Wilkerson Jr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other trau Kelley E. Presock/daughter 10116 Deal Island Rd., Deal Island, MD 21821 20b. Place of Disposition (Name of Springhill Memory) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 3/14/07 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association avice of Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Mexastalle /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, liany, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 1□ Yes 2/1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes → No 1 Inpatient within 24 hours after deam.

To the Funeral Director: After this of the funeral director with the funeral director. 2 2 ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending Iniury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital

requires that the death certificate be executed

Box 68760,

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or Vital Records,

Division or Attending

The

Baltimore, Maryland 21215-0036

Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

10

Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 200

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

			For Stata Registrar	State of Ma		partme <i>ertifica</i>			nd Mer		giene () (7	09534
	0 0		1. Decedent's Name (First, Middle, Last)							Date of Dea	th		3. Time of Death
	Physici /Medi		Robert Fred	erick	Widem	an				Month March	6, 2007	Year	1517 M
	Examir		4a. Facility Name (If not institution, give s PENINSULA REGIONAL		CENTER		, Town, or L ALISBI		Death	-	4c. County of WICC)
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	N 005	(In yrs. last birtho	Month		If Under 24 Hours	Min.	Date of Birth (Month, Day /16/19	, Year)	Cour	place (State or Foreign htry) aware
	P.		Usuat Residence of Decedent										
	aryiar phow	_	10a. State 10b. County		10c. City, Town o	r Location						1	0d. Inside City Limits
	8a-1	50	Maryland Wicomic	0	Sali	sbury							1x Yes 2 No
	vith d	2	10e. Street and Number			10f. Z	p Code			1	0g. Citizen of W	hal Cour	ntry?
	ath v	rai	200 Civic Ave.				21804				USA		·
36	should be filed within 72 hours after deeth with the Maryland of Mental Hygiene. marked other than "naturel", or flems 23s or 28s-f show imatic event, the Madical Examinar market be rediffed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 No If Yes, Give	0_	 Was Dec If Yes, sp 1 ☐ Yes 		panic Origin , Mexican, F <i>Specify:</i>	n? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race Black Specify:	, White,	an Indian, etc. nite
215-0036	hour	ed th	15. Decedent's Educ		Army	ecedent's Us	al Cocupati	ion			16h Kind of Bu		
15	n na	Completed	(Specify only highest grade	completed)	(G	ive kind of w	ork done du use retired)	ring most o	f working		16b. Kind of Bus	111622/111	dustry
212	Jiene Piene	E	Elementary/Secondary (0-12)	Coltege (1-4or 5+ 4+	-)	ccount					Mobile	Oil	Corp
ğ	il Hygid other	BeC	17. Father's Name (First, Middle, Last)					l8. Molher's	Name (Fi	rst, Middle, I	Maiden Sumame		JOLP
Maryland	s t and 2 should be of Health and Mental item 27 is marked cother traumatic even	ToE	William Franklin W 19a. Informani's Name/Relationship (Ty)			ailina Addra	o (Street on			Betts	; City or Town, S	24.4. 7:	0-40
<u>8</u>	nd 2 sho lith and 27 is m		Frances Holly Sch								y, MD 2		
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 iny or other tru		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R	emoval from State	20b. Place of Di cemetery,	sposition (National National N	me of other place)		Date	_	20c. Location - (
	t. Pa rtmen rtant: njury		4 Donation 5 Other (Specify)		Salisb				/9/07		Salisb		
<u>e</u>	permit. Pages Depertment of important: If it eny injury or o		21 Signal Unit of Service License	man	cese.	501	Snow H	Iill R	d, Sa	alisbu	ry, MD 2	al As 2180	ssociation 1
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused t	he death. Do not	enter the mo	de of dying,	such as ca	rdiac or re	spiratory arri	est,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		0				72013		
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	od sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):								
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×		Physician/Me	IF FEMALE:	3c. If yes, outcome o	foregnancy								
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7	w requires that the death certif been signed by the attending should be detached for use as	Y P	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying	cause given	in Part I.		23e. Did tob	acco use contril	oute to Ih	e cause of death?
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N I I I	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical							1□ Yes 2	1	Yes	2□ No
=		o Be	examiner?	ospital:	-55	-0-	Other			reck only on			
5	Phys	\vdash	27. Manner of Death	1 ☐ Inpatient			JA	4 Nursii			ince 6 Other		")
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UNISION	Attending ir death. ector: After by the funer	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home, farm,					Location (St	reet and Number	or Rura	I Route Number.
5	urs after	Certification;	4 Homicide	building, etc.	(Specify)					City or Town	, State)		
	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Att	edical	29a. Certifier 1 Certifying Phys. (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	ixaminalion and/oi	ath occurred investigation	at the time, n, in my opin	, date and p nion, death o	occurred a	due to the ca t the time, da	use(s) and man ate and place, ar	ner as st nd due lo	ated. the cause(s)
	To t	Σ	29b. Signature and title of certifier	11)		29	c. License n	number		25	d. Date signed	(Month,	Dey, Year)
	Ann 1		1 10 10	for			02	20	74	8	1/5,	1 -	7
	6mp		30. Name and address of person who cor	npleted cause of dea	ath (llem 23a) (Typ	e, Print)			,		1	0 1	
	1,		Dr. William H. Ro		200 Civio	ave.	, Sali	.sbury	, MD	21801			
	Sta Registra		31. Date filed (Month Par Year) 3 20	07 32. Segistrar	's Signature	Sparts	,						
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			1 - For State Registrar	State of N	Maryland / Depa <i>Ce</i> a	artment of H			giene	7	95	35			
	Ohoriai		1. Decedent's Name (First, Middle, Last)				2. Date of Dea		Year	3. Time o	of Death			
	Physici /Medic		Irvin H. Zim	merman			<u></u>	March	7, 200		2:30	P M			
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or		Death	4c. County of						
			Sunrise Assist			Freder		Use I		deric					
	Funeral Director		5. Social Security Number 6. Se 216-22-9956 Usual Residence of Decedent	X M 2□ F	Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birt (Month, Da Jan • 25	, Year) , 1927	Coun	lace (State try) Land	or Foreigr			
	fand ow		10a. State 10b. County		10c. City, Town or Lo	cation				10	Od. Inside C	City Limits			
	Mary -f sh	ţō	Maryland Freder	i ale	τ.	rederick					1 XYes	s 2 □ No			
	r 28a	Director	Maryland Freder 10e. Street and Number	ICK	F.	10f. Zip Code			10g. Citizen of W	hat Coun	try?				
	h wit	a D	990 Waterford Dr	ive		2	1702		United	Stat	es				
	ems er n	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S. 13.	Was Decedent of Hi	ispanic Origin'	? (Specify Yes or No- uerto Rican, etc.)	14. Race	- Americ					
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f show he Madical Examiner must be notified at	by Fu	1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced		□N∘1945-	1 ☐ Yes 🏋 No	Specify:	33.10		Whit					
ğ	2 hou	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup			16b. Kind of Bus	siness/Inc	lustry				
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	tal H d off	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Sumame	9)					
3	should be and Mental I marked o	2	Ray B. Zimmerman	0.11	1			Wachler							
<u>a</u>	12 sho h and l 7 Is me trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ryan Zimmerman / Son 9731 Daysville Rd., Walkersville, MD 21793												
	is 1 and 2 should be filled of Health and Mental Hyg item 27 Is marked othe other traumatic event,		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1	Date	20c. Location - (
altimore,	permit. Pages Department of H Important: If it eny injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ F		te cemetery, crei	natory or other plac	1	13/2007	rederic						
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	icate be executed physician and s the burial-transit	dlcal		d	beces Type	TT WICH K	CHAL II	iisui i i cici							
O. Box 6	ne death certii the attending thed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date Mon		ivery Day Year				
<u>a</u>			Part II. Other significant conditions co	ntributing to death	n but not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to th	e cause of	death?			
g	quires n sign bld be	d by	Gasto Esophageal R	eflux Di	sease			1 🗆 Y	es 2 No	3 🗌 Proba	abiy 4 🗌	Unknown			
Vital Records,	law requires as been sign 2 should be	Completed	Coronary Artery Di	sease. D	epression.			24a. Was a		ere autop	autopsy findings available				
ř	о <u>с</u> в	Ho			<u> </u>			— autop perfor 1 ☐ Yes	med? de	eath?	npletion of d 2□ No	cause of			
<u>ra</u>	icien: Th certificate rector, pag	Be C	Hypercholesterolem 25. Was case referred to medical	та, нуро	palbumemia		26. Place of	Death (Check only or			-				
> 0	Q 50 X	To	examiner? 1 ☐ Yes 27 No	Hospital: 1 🗆 Inpa	atient 2 ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursin	ng Home 5 ☐ Resid	ence 6 NOthe	r (Specify					
	ding P		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of it (Month, I	njury 28b. Time of Day Year) Injury	28c. Injury Work	</td <td>28d. Describe h</td> <td>ow injury occurre</td> <td>d 1</td> <td>iving</td> <td></td>	28d. Describe h	ow injury occurre	d 1	iving				
<u>S</u>	Attending r death. actor: After	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No								
Division	for Attendater death Director: In by the	Certification;	4 Homicide determined	28e. Place of building,	Injury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (S City or Tow	itreet and Numbe n, State)	r or Rurai	Houte Nun	nber,			
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier Certifying Phy	sicien: To the he	st of my knowledge, death	occurred at the tim	ne date and of	lace, and due to the	ralise(s) and man	ner as str	ated				
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	To the within Fo the complex	Me	29b. Signature and title of editifier	() .	11	29c. License	number	2	29d. Date signed	(Month, L	Dey, Year)				
	W.) Allen	Kell	KY M	D5474	.9		Marcl	h 8.	2007	*			
1	411,		30. Name and address of person who co	ompleted cause o	f death (Ivem 23a) (Type,		-		, IGE C	0,					
1	7		Allen Reilly, MD		lhouse Ave.		derick	, MD 21701							
	Sta		31. Date filed (Month Pay, Year) 3		strar's Signature										
	Registr	ar	111111 1 0 2	101	wa & d	Market 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 24, . 2007 **Physician ERNEST** C. ATKINSON SR. 2:45 рΜ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 226 Oak Drive Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Hours Months Days Yrs. Director 10,1927 Carolina 220-22-1657 79 North Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 2 226 Oak Drive 21122 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must 2 once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 **[Z**] Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 21 Married 1 ☐ Yes 2 No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Paint Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alford Clyde Atkinson Amelia Ernestine Hale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elsie L. Atkinson (Wife) 226 Oak Drive, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park 03-28-07 Glen Burnie, Maryland 21. Signature of Fundral Service Line McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland21122 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Months /Medical Due to (or as a consequence of): Examiner⁻ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Migrry that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1□ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Lath 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after To the Funeral Dire

Baltimore, Maryland 21215-0036

D39505 March 26, 2007 Hospital Dr. Glas Burnie, MD. 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Markan 305 ndhisht 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

🎼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	laryland / I	Departmer <i>Certifica</i>			nd Me		ene	07	09539
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside City Limits
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8760	physic physic the b	edicai		d									
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Ta		င္ပ	25. Was case referred to medical							1 ☐ Yes 2	No	1 ☐ Yes	2 No
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0	ding Ph h. After thi funeral		27. Manner of Death	28a. Date of Inj	ury 28b.		28c. Injury Work			d. Describe how			y)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** BARE FOOT March 18346 LOS A 23 TOOS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW NEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 F 216-32-2888 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r 28a-f show notified at Baltimore 1 Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with Innet of Health and Mental Hygiene. pe e 21223 23a must ! Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married ☐Yes 2▼No Yes, Give ò 1 ☐ Yes 2 ▼No Specify 3 Widowed 4 □ Divorced Year or Dates "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Modical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) the M College (1-4or 5+) 27 Is marked other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname 17. Eather's Name (First, Middle, Last) To Be 19b. Mailing Address (Street and Nun or Rural Route Number, City or Town, State, Zip Code) Item 27 I 20b. Place of Disposition (Name of Method of Disposition permit. Pages Department of Important: If It any Injury or o once. 1 Burial 2 ☐ Cremation Baltimore, MD 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signatur of Funeral Service I Services Balto, MD 21229 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pueumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Interstitial Pulmonau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Fibrosis Due to (or as a nonsequer Examine Sclenderma Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performe 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 I Director: After the in by the funeral within 24 hours a To the Funeral I filled

Baltimore, Maryland 21215-0036

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Medical

State Registrar 29b. Signature and title of certifier

29a. Certifier

29c. License number

RES-000

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

MARCH 23, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1N, MD 1940 Eastern Nenue BAUTIMORE, FASHOY IN LOLA A .

31. Date filed (Month, Day, Year)

MAR 2 7 2007

			1 - Stata Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H	lealth and Death		giene Reg. No.	007	09541
1	ar '.		1. Decedent's Name (First, Middle, Last)					2. Date of De.	ath	Vana	3. Time of Death
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	pug *		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation					10d. Inside City Limits
	haryla eho	5	SC 10b. County Oconee		Seneca						1 ☐ Yes 2 No
	28e-	Director	10e. Street and Number			10f. Zip Code			10a. Citiz	en of What Co	
	3a or	Ö	202 Eagles View Dr	•		10f. Zip Code 2967	8	0	US	en of What Co A	,
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0 7	Hygin Hygin Sther ant,		17. Father's Name (First, Middle, Last)	11/21			18. Mother's Na	me (Ficst Middle, la Ahlers	Maiden	Sumame)	
au	ould be filed within 72 hours after death with the Maryland Merial Hygiene. arked other than "natural", or iteme 23a or 28a-f show artic event, the Macinal Explainment court by motified at	To Be	Carl Herman Hespe				Matilo	la Ahlers			
Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene I proportent: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other treumatic event, the Marical Extrainment countries to notified at once.	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	and Number or A	lural Route Numbe	or, City or	Town, State, Z	Zip Code)
Σ	and 2 alth a		Mary Parham		202 1	Eagles Vi	ew Dr. S	seneca, s	C 29	6/8	
altimore,	of He of He fitem		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ Re	mousi from State	cemetery, crer	sition (Name of natory or other place	(e)	Date		cation - City or	
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Balt	eparti eparti nport ny inj		21. Signature of Funcial Service License	9	22 Pa	Name and Address	s of Events F	uneral Cha	œ. &	Crematic MD 21 34	nS-rvices
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	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):						
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	o the vithin ; o the omple	Mec	29b. Signature and title of certifier	and manner stated. and manner stated. and manner stated.		29c. License	e number		29d. Date	signed (Month	h, Day, Year)
•	->-0		Wend Klosz	****		D.	31295		Z	122/02	
	Jo		30. Name and address of person who con	npleted cause of death (Ite	m 23a) (Type,	Print)	/ 3		,,	771070	
	1.		Wendy Kloesz	6701 N Ch.	-105 S	4 Suite 4:	264 To	owser.	mil	2/20	4
(8 ⁴)	Sta		31. Date filed (nth, Day, Year)	32. Registrar's Sign	ature	7-0-					
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				/pe or Print in B l State of Maryland				_		_	
			For State Registrar		Ce	rtificate of	Death		Reg. No	2007	09542
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Stephen Thomas Bake	er,Sr.				2. Date of De Month		¥5, Ž%	3. Time of Death
)	Examin		4a. Facility Name (If not institution, give st Saint Joseph	reet and number) Medical Cen	ter	4b. City, Town, or	Tows		40	County of Dea	th ltimore
	Funeral Director		219-20-1050	7. Age (<i>In yr</i> s. <i>Ia</i> 74	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July	th 3y. Year 2, 1	9. Bir 932 Balt	thplace (State or Foreign puntry) LIMOYE, MD.
	laryland show ed at	٥٢	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 🛂 No
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0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show myn hjury or other traumatic event, the Medical Examiner must be notified at once.	by Funera	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces? 1 Mayes 2 No Kore If Yes, Give Year or Dates: Conf	ean	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Ame Black, Whi	
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2	should nd Me mark imati	မ	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Maili	ng Address (Street			per, City	or Town, State,	Zip Code)
N N	nd 2 alth al 27 is r trau		Sadie May(nee Stro	n)Baker(Wife)	611	Rocky Hi	ll Road	Sparks	s,Mai	ryland	21152
oallimore,	Pages 1 annount of Herunt of Herunt of Item		20a. Method of Disposition 1	CG CG	emetery, cre	osition (Name of matory or other place Meth.Ch.(Date Ch 28,)7		ocation - City or	
סמור	permit. Departr Importa any Inji		21. Signature of Funeral Service License	· Jan, er	-1 23	325 York :	Road Tin	nonium,N	lary	&Cremati land 21	ion Ctr.,P.A 1093
	346		23a. Party. Errer he dise & , or complice shock, he rt failure. List only on	a o s that caused the death e use on each line.	. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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O. DOX 00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome pf pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Date of de Month	elivery Day Year
1	that the by detact	y Ph	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
	quires n sigr uld be	d by	END-STAGE CHRONIC	OBSTRUCTIVE P	ULMON	ARY DISEA	ASE	1 🗆	Yes :	2 X No 3□ F	Probably 4 □Unknown
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DIVISION OF	tending Peath. tor: After the funera	Certification:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	28b. Time (M 1	Yes 2 □ No	28d. Describe		,	
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	the Hosk nin 24 hoi the Fune	ledical	(Check only 2 Medical Examir one)	ician: To the best of my knowner: On the basis of examinat and manner stated.	vieage, dea ion and/or i	th occurred at the ti nvestigation, in my	opinion, death occi	e, and due to the urred at the time	e, date a	s) and manner and place, and du	ue to the cause(s)
ŀ	Vorti	N	29b. Signature and title of certifier A. J. Hold	ч, м. Д.			17695				5,2007
	1041		30. Name and address of person who co				DEINE	ТПЫВПЫ	_ lyi	ARYL AN	D 21204
l y	,	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	tuge,	Jan M. B	dat 1.5 sh. V from 0	. weventully	9 11	virit hos ETET	

DHMH 17 Rev 1/2001

Registrar

MAR 2 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** March 23 2007 8:10 p. Joseph F. Baer, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Nursing Center
5. Social Security Number | 6. Sex | 7. Towson
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Director Aug. 10, 1923 Maryland 83 215-14-4469 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show be notified at 1 ☐ Yes X☐ No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must. 817 Loalan Avenue 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ✓ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Longshoreman-Checker Import/Export 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph F. Baer, Sr. Marie Hagan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7313 Berkshire Road Baltimore, Maryland 21224 Joan Darchicourt (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 ☐ Other (Specify) Sacred Heart of Jesus 3/26/2007 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) nset and Deatl UROSEP 2 weaks **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ terroscleratic cardiovascular disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1□ Yes 1 ☐ Yes 2 No Division or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospics 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 | Pending Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

##AD 9 77 200

31. Date filed (Month, Day,

endallik taulkner MD

32. Aggistrar's Signature

555 W. Tausontaun Blud

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Martin Edward Bengston March 24, 2007 11:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Manor Care Towson Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 1) | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2 □ F Yrs. Director 80 219-18-3134 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Show r then "neturel", or items 23e or 28a-f shov the Medical Evarifier must be notified at 1 ☐ Yes 2 X No Funeral Director Marvland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1743 Wycliffe Road 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Be Completed by White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Group Leader B.G.E. es 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie if item 27 is marked other to other treumatic event, II. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard E. Bengston Eleanor E. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) vnt: If item 27 is n 1743 Wycliffe Road Parkville, Maryland 21234 Audrey Bengston - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State rtment Dulaney Valley Memorial 03/29/2007 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. rales Baltimore, MD 21214 Munes 23a. Part1. Enter the dise 💉, or complicati shock, or heart failur . List only one or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) I Yes 2 No the a ģ signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYAS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 20 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier D 30433 . 01 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) BHT, MORE 6701 MALLYMO N. CHARLES 32. Flashar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5.43 AM 26, 2007 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 400 John 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1**X**M 2□F Yrs. Director 212-26-5433 78 12/23/1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 1XYes 2□No Director Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2005 Bank Street 21231 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Www. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Pipe fitter Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Burdyck <u>Stella M. Morawska</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Marlene Burdyck - Former Wife</u> <u> 2005 Bank Street Baltimore, Maryland 21231</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Jesus 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 R 3 ☐Removal from State 03/30/2007 Baltimore, Maryland Cemetery ure of Funeral Service License 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Pakt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YulmonArmonths /Medical Due to (or as a consequence of): Examiner E Sequentially list conditions, if any keeling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du vio (or as a conse uence of) be executed Exami neu monia burial-trar and Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1☐ Yes 2☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 I Inknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 3 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Tes 2[] No 2 ER/Outpatient 3 DOA Certification: To this funeral . Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After e Hospital or Attending 24 hours after death. Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

h

State Registrar 29b. Signature and title of certifier

MAR 2 7 2007

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harisha Cook, The Johns Hooking Hooking Hooking Hooking Hooking 132. Registrar's Signature

29c. License number

WOIFE St

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Doris L. Bennett March 200 25 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Posedale wave If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 19, 1919 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Days Months Min 1 □ M 2 🔀 F 412 28 6888 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 803 S. Marlyn Avenue 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Production Planner Aerospace 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Jefferson Mosley Elizabeth Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 634 Hornbeam Rd. Edgewood, Maryland 21040 Danny Bennett (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ★Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 3/29/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) a∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 2☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

law requires that the death certificate be executed physician and s the burial-trans Box 68760 as attending p for use as ed by the a detached f Ö ۵. signed b Division or Vital Records, icate has l

Hospital or Attending

certificate director, this funeral After To the Hospital or within 24 hours after death.

To the Funeral Director: Af

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be I

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once.

Physician /Medical

Examiner

Maryland 21215-0036

Itimore,

Director

Funeral

Completed by

Be

Examiner

Physician/Medical

2

Completed

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Certification:

Medical

State

Registrar

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide 29a. Certifier

(Check only one)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

es 00000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Adedouin 31. Date filed (Month, Day, Year) Tide 9000 Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Month Day **Physician** 25, Mabel Lucille Bowling 2007 March 2:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2√F 300-22-1858 May 14, 1929 WV Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County MD Harford 1 ☐ Yes 2 No Forest Hill Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or 2 must be n 108 M 21050 Gwen Drive USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, th and Mental Hygiene.
7 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A.Bowman Mabel Damron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Bowling/Son item 27 i 177 Range Rd Windham, NH 03087 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any Injury or once, Metro Crematory, Inc 3/27/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George E. MacNab Cremation Society of Maryland, Inc 299 Frederick Rd Baltimore, MD 21 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of thing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical attending p for use as 1 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 1 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Tes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

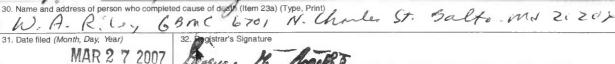
To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

To the F

State Registrar 31. Date filed (Month, Day, Year) MAR 2

2007

29b. Signature and title of pertifier



25205

29d. Date signed (Month, Day, Year)

MArch 26, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23 2007 5:14 a March Garv Benfield /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Hospice Timonium if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, APR 17, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral ™** M 2□ F 61 577-58-5561 Director Usual Residence of Decedent with the Maryland 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2X No 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified Director Anne Arundel MD Pasadena 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 21122 USA 8100 Foxberry Lane Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ★Yes 2 ☐ If Yes, Give Year or Dates: 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced 65 - 69White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry perint. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic evens. Elementary/Secondary (0-12) College (1-4or 5+) 8 Automobile Mechanic Automotive Garage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Cecil Benfield Lucas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) Falco Benfield - son 8100 Foxberry Lane, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 3/24/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Heart H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causeion each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCERWITH METASTASIS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No certificate Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 tother (Specify) 2[No 3□ DOA ို 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Type, Print TARI MANMOOD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

Registrar
DHMH 17 Rev 1/2001

MAR 2

2007

			For State		State of	Marylan	-	artmen				lental Hy	giene Reg. No.	20	0.7	00	1550
			Registrar 1. Decedent's Name (First,	Middle, Lasi	·)			imoan		Joann		2. Date of De		6_ 0	VI	3. Time	of Death
	Physici	_	Treasy	P	21120							Month 03	Day 2		2007	19	16 PM
	/Medio		4a. Facility Name (If not insi	itution, aive	street and numb	per) .		4b. City.	Town, or	Location	of Death	0.0			of Death	111	101
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	Funeral		5. Social Security Number	6. Se	. 14-	. Age (In yrs.	last birthday)	If Under		If Under		8. Date of Bi	rth	u	9. Birthp	ace (State	or Foreign
e e	Director		226-48-3497	X	X M 2□ F	66	Yrs.	Months	Days	Hours	Min.	(Month, D.			Coun	$\mathbf{V}_{i}^{(ry)}$	A
	PL ,		Usual Residence of Decede			10- 0	Town or La	antina							14	Del Innide	0:11:-::-
	arylar show	_	10a. State 10b. C	ounty			ty, Town or Lo timore	callon							''		City Limits es 2 ☐ No
	he M 28a-f otifie	ecto	10e. Street and Number			Dai	CIMOIC	105 %	Onda				10a Citi	izon of l	What Coun		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	3326 Elmley	Δτιο				10f. Zip	213						Wilat Couli	uy:	
	be filed within 72 hours after death w ttal Hygiene. d other than "natural", or items 23a event, the Medical Examiner must b	era	11. Marital Status	1100.	12. Was Deced	ent Ever in U	l.S. 13.			ispanic Or	iain? (Sc	ecify Yes or N		3.A. 14. Rac	e - Americ	an Indian,	
	ter d item iner	ᇤ	1 Never Married 2	Married	Armed Ford	es? ![X No		If Yes, spec	cify Cuba	ın, Mexica	n, Puèrto	ecify Yes or No Rican, etc.)			ck, White,	_	
336	urs al	β	3 ☐ Widowed 4 💢 Div		If Yes, Give Year or Dat			1□Yes	2 <mark>∏</mark> No	Specify:				Specify	Bla	.ck	
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Maryland	S S S		19a. Informant's Name/Rel			امدد		•	,			ral Route Numi				Code)	
	1 and Health	-	20a. Method of Disposition	OL ICK	S / FITE		3320 Place of Dispo			ve.,	ватт	imore,			City or To	wn State	
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Baltimore,	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Ot 21. Signature of Funeral S			,,,											
Ba	permit. Pag Department Important: I any Injury o			. 1	3	M01452	2 2	210 1	Dal	1+1	"Ren	don-Bai	Lley	Fune	eral	Home,	PA
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	Dharisian		sho k, or heart failure Immediate Cause (Final	. List only o	one cause 'n ea	ch line.	1 1	20 _{16.}	17				_	•		Interval E Onset an	Between Id Death
	Physician /Medical		disease or condition resulting in death)	-	a. 1770	ras a consec	uence of):	0	(in	de	10250	ular	Dik	ice	-	hos	255
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		<u>e</u>	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		b. Due to (o	r as a consec	quence of):	1100								-	
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9	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:														
Box	leath certific attending p I for use as	an/l	23b. Was decedent pregna	nı	23c. If yes, outco 1 ☐ Live bir	ome pf pregn th 2 ☐ Feta		∃Ectopic pr	regnancy	,			103		ite of delive	ny Day	Year
	e dea	sici	in the past 12 months 1 ☐ Yes 2 ☑ No	f		nt at time of o		Other (sp						IVIC	סוונוו	Day	rear
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ec	e law las b	Pg.		1/21	ahe far	Mel	to the					24a. Was	psv	24b.	Were auto prior to cor	psy finding	gs available f cause of
E		Sol										1□ Yes	ormed2 2 No	<u>, </u>	death? 1 ☐ Yes	2 No	
Vital	Physician: r this certific ral director,	Be	25. Was case referred to mexaminer?		Hospital:		/		Oth	OF:		th (Check only					
or	Phys this a	은	1 Yes 2 No	Į	1 ☐ In		ER/Outpatie			4 🗆 N	ursing H	ome 5 Res				1)	
n C	ding I J. After funer	ion:		ending	(Month	, Day Year)	Injury	" _M]	8c. Injur Worl	yaı k? Yes 2. □	INo	28d. Describe	now inju	ry occur	rea		
Si	Attending r death. ector: After by the fune	icat	3□ Suicide 6□(ould not be		of injury - At h	l jome, farm, st	-		163 2	1140	28f. Location	(Street ar	nd Numi	her or Rum	I Route N	umber
Division	after Direction by	Certification:	4 Homicide	letermined	buildin	g, etc. (Speci	ify)		,,			City or To	wn, State	9)	JOI 01 71410	. , , , , , , , , , , , , , , , , , , ,	a.,
	ospital hours uneral		29a. Certifier 1 Ce	rtifying Phy	ysician: To the b	est of my kn	owledge, deat	h occurred	at the tir	ne, date a	nd place	, and due to the	e cause(s) and m	anner as s	tated.	
	24 H at	Medical	(Check only 2 Me	dical Exam	iner: On the bas and manne	sis of examina	ation and/or ir	nvestigation	n, in my c	pinion, de	ath occu	rred at the time	e, date an	d place,	and due to	the caus	e(s)
	To the within To the Comple	Me	29b. Signature and title of	ertifier	10				1	e number				-	ed (Month,		
			> Paller	4/4	K				0	385	43		Ma	ul	22.	200	27
7	2		30. Name and address of p	erson who	mpleted cause	of death (iter		Print)	, , ,	,	~	ulevan	-		/ -		
	σ		KEVINK	1. 5	Leuges	un	5601	Loca	LE	war	Bi	ulevan	V 12	milt	sur	u	aufush

State Registrar

			For State Registrar	State of Marylan	-	artment of I			jiene	7 09551
	Physici		1. Decedent's Name (First, Middle, Las	ORRAINE	BI	AIR		2. Date of Dea		gar 5.5/ M
).	/Medic Examin		4a. Facility Name (If not institution, five		ER	4b. Gity Town,	or Location of De	EA	4c. County of	Posth POLL
1	Funeral Director		217-20 0513	ex 7. Age (In yrs. 79)	last birthday) Yrs.	If Under 1 Year Months Days			Year 7727	Bignplace (State or Foreign
	Maryland f show	or	Usuel Residence of Decedent 10a State 10b County ARKO	10c. Cit	y, Town or L	cation 576	FR			10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 13a or 28e- st be notif	ai Director	10e. Street and Number /////	LANE	2017	10f. 2mg Code	8	1	log. Citizen of What	at Country?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28e-f show other traumatic evant, its Madical Examinal must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		Was Decedent of if Yes, specify Cut		(Specify Yes or No- erto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc.
21215-0036	filed within 72 h Hygiene. other than "natu ant, Ire Moderi	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DONOT use retire	pation during most of v	vorking	16b. Kind of Busin	ness/Industry TAL
Maryland	should be file nd Mental Hy marked oth imatic evant	To Be	17. Father's Name (First, Middle, Last)	A. CH	HEW		18. Nother's N	lame (First, Middle,	Maiden Surname)	COKER
	1 and 2 sho Health and tem 27 is ma		HELVIND BAIR SK	HUSBAND	1509	Chis	Land Number or	Rural Route Number	r, City or Town, St	19. Zip Code) 10 - 21158
Baltimore,	Page nent c int: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State 400. F	Place of Dispo cemetery, cro	esition (Name of trajory or other pla	11W 3	-26-67	20c. Location - Ci	ty or Town, State (1).
Balt	permit. Pag Department Importent: eny Injury o		21. Stinatury Fine Servic Licen	8 0 0	12	Name and Addr	ess of Fagility	SHE ACIN	ST WES	(MINSTERA).
16.5	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the deat one cause on each line.	h. Do not en		ing, such as card	iac or respiratory arr	rest,	Approximate Interval Between Onset and Death
# 195	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
60,	ate be executed hysician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence) Due to (or as a consequence)						
k 68760,	ate hy:	Medica	IF FEMALE:	d						i
.O. Box	The law requires that the death certific tle has been signed by the attending pl age 2 should be detached for use as:	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnand Other (specify)	ey .		23d. Date of Month	
rds, P.	w requires thei been signed t should be det	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause gi	ven in Part I.			ute to the cause of death?
of Vital Records,		Completed						24a. Was a autops perform	med? pric	re autopsy findings available or to completion of cause of th? Yes 2 \(\subseteq \) No
/ita	Physicien: This certificaral director, p	Be	25. Was case referred to medical examiner?	11		/ 10		eath (Check only on		
ion of	ng Phys fter this neral dii	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju		Home 5 Reside	ence 6 Other ow injury occurred	
Division	el or Attendii s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str y)	reet, factory, office		28f. Location (S. City or Town		or Rural Route Number,
	To the Hospitel or Ai within 24 hours after or to the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the t vestigation, in my	ime, date and pla opinion, death of	ce, and due to the c curred at the time, d	ause(s) and mann late and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	M	29b. Signature/and title of certifier	MO			se number		9d. Date signed (I	
1	4		30. Name and address of person who	0 0	Λ	Print)	Wey	munta	M0 2	1157
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 7 2007	32. Registrar's Signa		وع				

			1- State of Maryland / Department of Health and Maryland / Certificate of Death	Mental Hygie	71111	09552
	Physici		1. Decedent's Name (First, Middle, Last) Glen L. Brainard	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Baltimore Weshington Medical Conter, Color	1	4c. County of Death	Armdel
	Funeral Director		5. Social Security Number 298-18-0452 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 04/18/19	ear) Cou	place (State or Foreign ntry) OH
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	he Mar	Director	MD Anne Arundel Millersville	1.2		1 ☐ Yes 2 📉 No
	h with t	i Dir	10e. Street and Number 8173 Veterans Highway Trailor 76 21108	10g.	. Citizen of What Cou USA	,
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other then "naturel", or Itama 23a or 28a-f show sumatic event. Its Madical Examination mails the notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 ▼ Si Give 1 ▼ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto If Yes, Give 1 □ Yes 2 ▼ No Specify:	Decify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White Specify: Whi	, etc.
Baltimore, Maryland 21215-0036	ithin 72 houne.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	b. Kind of Business/Ir	ndustry
d 21	filed w Hygie Other t	CO	12 Tool and Dye Make 17. Father's Name (First, Middle, Last) 18. Mother's Nam	er ne (First, Middle, Mai		A.I.
ylan	should be and Mental I marked o umatic eve	То Ве	John Brainard Mary	Brainard		
Mar	end 2 sho ealth and n 27 ie m		19a. Informant's Name/Relationship (Type, Print) Mr. Matthew Brainard / son 7618 Bagley Avenue,		city or Town, State, Zi le, Maryla	
Jore,	permit. Pages 1 and 2 should by Department of Health and Monta Important: If Item 27 is marked any Injury or other treumatic a 2008.		20a. Method of Disposition 1 Burial 2 XX remation 3 Removal from State	Date 20d	c. Location - City or T	own, State
altin	permit. Pa Departmen important any injury once.		4	26/2007 Singleton	Stevensvi Funeral H	
m	80 5 6 8		Mol357 1 Second Avenue,			
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	or respiratory arrest,	,	Approximate Interval Between Onset and Death
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	and transit	Examine	causé. Enter Undertying Cause (Disease or injury that initiated events c.	enza		
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õ	eath certifica attending ph I for use as ti	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		204 0-1-445	
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rds, P	quires thet n signed t uld be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to t	1
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Tall L		e Cor	25. Was case referred to medical 26 Place of Deal	performed 1 Yes 2 th th (Check only one)		2 No
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o uois	l or Attending Physician: after death. Director: After this certifica i in by the funeral director,	Certification;	27. Manner of Death 1	28d. Describe how	injury occurred	
DIVISION	al or Att s after de il Direct	Sertific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hoepital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the caus red at the time, date	e(s) and manner as s and place, and due t	stated, o the cause(s)
	To t withi	ž	29b. Signature and title of certifier 1 29c. License number 1) 4 8 0 0 6	29d.	Date signed (Manth,	Day, Year) 2007,
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	(5) am	3/22/2 Inrn	14, mn
\$	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 7 2007 32. Registrar's Signature	1		

Brainard

2 DNo e tites:	4b. City, Town, or Location 4b. City, Town, or Location 1f Under 1 Year If Under 1 Year Hours	2. Date of Death Month Mar of Death Catonsville 24 Hrs. Min. 8. Date of Birth (Month, Day, August 26 fille 1228 rigin? (Specify Yes or Nonn, Puerto Rican, etc.)	Day Year Tch 17, 2007 4c. County of Death Ba Year) 5, 1957 Og. Citizen of What Cou	Altimore pplace (State or Foreign unity) Maryland 10d. Inside City Limits 1 □ Yes 2 No
derick Rd. 7. Age (In yrs. last birthda) 49 Yrs. 10c. City, Town or I dent Ever in U.S. ces? 2 ISNo etes:	4b. City, Town, or Location 4b. City, Town, or Location 1f Under 1 Year If Under Months Days Hours Location Catonsv 10f. Zip Code 21 3. Was Decedent of Hispanic Of 1 Yes 2 No Specify 2 Code Code 2 Code Code 3. Was Decedent of Hispanic Of 4b. City, Town, or Location Catonsv 10f. Zip Code 2 Code 2 Code 3. Was Decedent of Hispanic Of 4b. City, Town, or Location 4b. City, Town, or Loc	of Death Catonsville 124 Hrs. 8. Date of Birth (Month, Day, August 26 Mille 1228 1228 1228 1328	4c. County of Death Base Year) 9. Birth Cot St. 1957	altimore nplace (State or Foreign unity) Maryland 10d. Inside City Limits 1 □ Yes 2 No
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2 (The state of the 1 Yes 2 No Specify		14. Race - Amer Black, White		
ites: 16a. Dec	cedent's Usual Occupation		Specify:	, 80.
(Giv	cedent's Usual Occupation		Specify.	White
-4or 5+) life.		st of working	16b. Kind of Business/I	ndustry
	. DO NOT use retired)		Loc	ksmith
	Business O	WNEr er's Name (First, Middle, M	4-14 0	
	ia. Mott	ers Name (First, Middle, N	alden Sumame)	
105 14-	(C)		ily Wachter	E- On do)
19b. Mai	tiling Address (Street and Numb		SC 000000000	ір Соав)
Sister 20b. Place of Disc	11803 Sherbourne D		land 21093 20c. Location - City or 1	Town State
	rematory or other place)		.oo. coodiion oity or i	iomi, otato
Bay	yview Crematory	03/22/2007	Baltime	ore, MD
that is seen if	22. Name and Address of Facil	ALCOHOLO CALANDO		
TUDIES	Slack Funeral 3871 Old Col.	mome, P.A. Imbia Pike Ellicott	City, MD 21048	Approximate
ach line.	Slack Funera 3871 Old Col. enter the mode of dying, such as	s carriac or respiratory arre	54.	Interval Between Onset and Death
reesclere	ofic Caldus	rasculae [isease	Jeals
or as a consequence of):	ofic Caedios before Melli	(O
or as a consequence of):	betes mem	tres		
<i>y</i> (
or as a consequence of):				
come of pregnancy			23d. Date of deli	verv
rth 2 Fetal death 3	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
wn				
ath but not resulting in the	underlying cause given in Part	I. 23e. Did tob	acco use contribute to	the cause of death?
		1 ☐ Ye	s 2 No 3 Pro	obably 4 Unknown
Pulminae	. NE	24a. Was ar	24h Wara au	topsy findings available
ouminal	y Hoease	autopsy perform	y prior to c	completion of cause of
		1 ☐ Yes 2	No 1 ☐ Yes	2 No
	Other	e of Death Check only one	- 1	father's
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of Injury 28b. Time h, Day Year) Injury	oncon racioly, office	City or Town	, State)	really rearray of ,
		nd place, and due to the ca	use(s) and manner as	stated.
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oth		e best of my knowledge, death occurred at the time, date a lasis of examination and/or investigation, in my opinion, de ner stated.	asis of examination and/or investigation, in my opinion, death occurred at the time, da ner stated. 29c. License number	

07-02221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Physici		State of Maryland / Department of the State of the State of the	of Death	Reg. No. 2. Date of Death 3. Time of Death	
al Exam	iner	John Scott Broaddus		Month Day Year 2153 hrs	
		Facility Name (if not institution, give street and number) 10341 Congressional Court	4b. City, Town, or Location of Death Ellicott City	4c. County of Death Howard	
Funeral Director		5. Social Security Number 2 1 9 . 0 2 . 3 0 4 0 6. Sex 1 7. Age (In yrs. last birthday) 4 0 4 0 4 0 4 0 4 0 6 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 11/11/1966 Foreign Country) Was	sh.
, any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local 10c. City, Town or		10d. Inside City	
te Maryland or 28a-f show fied at once.	ρ̈́	MD Howard E	Illicott City	1 Yes 2	XNo
th the Maryland 23a or 28a-f sho notified at once.	Dire	10341 Congressional Court	21042	U S A	
death wi r items nust be	nue	1 Never Married 2 Married Armed Forces? If Yes 2 No	/as Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto I Yes 2 No specify:		k,
hours al "natural Examin	ted by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of w most of working life. DO NOT use retir		
filed within 72 hours after I Hygiene ed other than "natural", o t, the Medical Examiner I	Completed	4 Cert	ified Public	Accounting	
ould be filed Mental Hyg marked oth	Be C	17. Father's Name (First, Middle, Last) John Jennerfer Broaddus		(First, Middle, Maiden Surname)	
2 should and Me 27 is ma matic ev	입	19a. Informant's Name/Relationship (Type, Print) Ms. Jennifer Broaddus wife 2234		wral Route Number, City or Town, State, Zip Code) Woodstock, MD 21163	
permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20c. Place of Dispos	osition (Name of cemetery,	Date 20c. Location - City or Town, State 8/07 Marriottsville	, M
permit. Departi Importi		21. Signature of Funda Gervice Licensee 22.	Name and Address of Facility Sla 71 Old Columbi	ck Funeral Home, P.A. a Pike, Ellicott City	
nysician Medical	S 7.	Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a Hanging	the mode of dying, such as cardiac or	respiratory arrest, shock, or heart Approximate I Between Ons Death	set and
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of):			-
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			_
ed nsit	Examine	(L'espasse or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ate be executed hysician and e burial - transit	Medical	d d			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. With a Valous after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Me	past 12 months? 4 Pregnant at time of death 5	retal death 3 Ectopic pregnar	23d. Date of delivery Month Day Ye	ear
that the dened by the detached for	P.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of dea	
quires that en signed ald be deta	ted by			1 Yes 2 No 3 Probably 4 Unk 1 24a. Was an 24b. Were autopsy findings av	
e law requi e has been ge 2 should	Completed			autopsy prior to completion of cau performed? death?	
certificate ector, page	Be Co	25. Was case referred to medical	26.Place of Death (Check of		
hysician: this certif al director,	10 B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier		g Home 5 ☐ Residence 6 ✔ Other: Scene	
nding Plath. r: After he funera		27. Manner of Death 1 Natural 5 Pending 28a Date of Injury 28b. Time of FOUND: FOUND: FOUND: FOUND: POUND: 23.2007.		28d. Describe how injury occurred Subject hanged self	
pital or Attending Physician: The law require ours after death. eral Director: After this certificate has been si filled in by the funeral director, page 2 should b	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Single Family		28f. Location (Street and Number or Rural Route Number or Town, State) 10341 Congressional Court, Ellicott City, Md.	er, City
e Hospita 124 hours e Funeral letely fille		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence only	urred at the time, date and place, and	due to the cause(s) and manner as stated.	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
1	-	Pare Har Dan	O.C.M.E.	March 23, 2007	
	1	20 Mary 1 and 1 an			
1		Name and address of person who completed cause of death (Item 23a) Carol Allan, MD	Street, Baltimore, MD 2120	1	

			For State Registrar	State of Maryland		artment of F			giene 07	09555
15	Physici	an	Decedent's Name (First, Middle, Last	")				2. Date of De Month		3. Time of Death
	/Medic	al	Albert E. Cummir 4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Dea	March	23 , 2007 4c. County of Dea	8:00 a. M
	Examin	er	Heritage Center	anost and mannes,		Dunda			Baltimor	
ia i	Funeral		5. Social Security Number 6. Se	TM 2□F		If Under 1 Year Months Days				thplace (State or Foreign ountry)
	Director		215-22-6477 X	79 79	Yrs.			Jan.	20, 1928 N	Maryland
	ryland how		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	8a-f s	ecto	Maryland Balti	more	Dunda					1 ☐ Yes 2 No
	with the	Funerai Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	,
	death	nera	505 Bayside Drive 11. Marital Status	12. Was Decedent Ever in U.S	S. 13.)	212 Was Decedent of H		(Specify Yes or No arto Rican, etc.)	United St	erican Indian,
92	or ite		1 ☐ Never Married 2 🖾 Married	Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give		r Yes, speciny Cub. 1 ☐ Yes 2 🛣 No		eno Hican, etc.)		
5-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates: WW	III	dent's Usual Occup	ation		16b. Kind of Business	hite
215	nin 72 Ju "na Medic	Completed	(Specify only highest grad	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of w	orking	TOD. KING OF BUSINESS	unidustry
2	filed withi Hygiene. other than	Com	8 years	College (1-401 34)	Truck	er			Trucking	
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<u> </u>	should be ind Menta a marked umatic ev	2	Raymond Cummins 19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	na Address (Street		ine Malcz Rumul Route Numbe	Zewski er, City or Town, State,	Zip Code)
	tra tra		Margaret G. Cummi	ns (Wife)		Bavside			e, Marylan	
altimore,	es 1 an of Heal of Item 3 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. PI	ace of Dispo	sition (Name of natory or other pla		Date	20c. Location - City or	Town, State
Ē	t. Pages tment of rtant: If it		4 □Donation 5 □Other (Specify)	Sac		eart of J		27/2007	Dundalk,	Maryland
g B	permit. Pages Department of I Important: If Ite eny Injury or of once.		21. Signature of Funeral Service Licens	Gee C	22	Name and Addre	iss of Facility Funeral	l Home of	Dundalk, Maryland	Inc.
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused the death	. Do not ent	922 Wise of dyir	: Avenue ng, such as cardi	Dundalk ac or respiratory a	rest,	21222 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a CORDIVAK	ZYA	RTE	RY.D	1 (FASI		Onset and Death
1,6,	/Medical Examiner		resulting in death)							
2	± X	-	Sequentially list conditions,	b. MITICAL Due to (or as a consequ	ence of):	TUE K	CPLAC	EMEN	/	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of the consequence o	OBST	RUSCFI	VI YEL	MONAR	y DISEAS	É
Ö,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	ence or):					
68760	ate he	dicai		HYPEKT	CNS	יאו				
Box	eath certific ettending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		-			23d. Date of de	livery
	000	Physician/Mec	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown]Ectopic pregnancy] Other (specify)	/		Month	Day Year
J.	that the de ed by the detached		9 ☐ Unknown Part II. Other significant conditions conditions		Iting in the u	adorbina nauca au	on in Dort I	23a Did t	obacco use contribute to	o the cause of death?
ds,	8 5 0	d by	Tarrii. Other significant conditions co	minothing to death but not resu	iting in the u	idenying cause giv	en in Pail I.			robably 4 Dunknown
ecords,	sw require s been sig 2 should b	Completed						24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Ÿ	sician: The law certificate has l irector, page 2 s	mo							prior to death? 2 □ 1 □ Yes	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	In a situl				eath (Check only o		
<u></u>	Phy this	. To	1 Yes 2 No		R/Outpatien		4 Nursing		dence 6 Other (Spe	ecity)
0	nding th. :: After e funer	ation	t Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200. 50001150 1	iow injury occurred	
Division	or Attending ifter death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (S City or Tou	Street and Number or R	ural Route Number,
	urs aft									
	To the Hospital or Atten within 24 hours after deal To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death on and/or in:	occurred at the tire vestigation, in my control	ne, date and pla- pinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mor	th, Day, Year)
}	7		Savinder	LE SCOLL R	0)	ル	271	88	3/2-3/0	7
-			30 Name and address of person who co	ompleted cause of death (Item	23a) (Type,	Printy Plan	· Dell	Ala	(0%) 7/5	222
Carte	Sta	te	31. Date filed (Month, Day, Year)	32. Fagistrar's Signat	UY /C	of I W	e mil	Care 1	011) 212	, 4
	Registr	_	MAR 2 7 2	2007 Alseus J	15. Ja					

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And the forces of the second o	th the 23a o		6703 North Point Road 21219	aun? / Specify Vo			
22 Name and Address of Soully 12 Name and Address of Soull	ath wi	ner	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican,				Car malan, Didok,
22 Name and Address of Soully 12 Name and Address of Soull	er de:		Yes 2X No			Specify: Wh	ita
22 Name and Address of Soully 12 Name and Address of Soull	urs aft iuraf'		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give	kind of work don	ie 16	1111	
22 Name and Address of Soully 12 Name and Address of Soull	2 hou	ete	during most of working life. DO NOT	use retired)			
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22 Name and Address of Soully 12 Name and Address of Soull	21. be fill ntal l- rked		Scott Kenneth Carpenter Kar	en Mari	e Pet	erson	
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22 Name and Address of Pauline Purklet and Address of Pauline	re, slan flea		200. Motified of Biopodition	Date	-	oc. Edcation - City of	Town, State
23. Barria Enter the disease, or complications that caused the death Do not enter the finded of light Address of early many that initiated events reculting in death but continues. Sequentially in death of the disease or complications that caused the death Do not enter the finded of light, Address of early and the continue of the caused finded events reculting in death but not resulting in clearly but not received events reculting in death but not resulting in clearly but not received events reculting in death but not resulting in clearly but not received events reculting in death but not resulting in clearly but not received events reculting in death but not resulting in clearly but not received events reculting in death but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in clearly but not resulting in the underlying cause given in Part I. 22a Date of delivery Year 22b Was case referred to medical events and but not resulting in the underlying cause given in Part I. 22a Date of delivery Year 22b Was case referred to medical events and but not resulting in the underlying cause given in Part I. 22a Date of delivery 22b Was case referred to medical events and but not resulting in the underlying cause given in Part I. 22a Date of delivery 22b No 23 Finds of Date (Cineck only yone) 22b Was case referred to medical events and but not resulting in the underlying cause given in Part I. 22a Date of delivery 22b No 25 Pinds of Date (Cineck only yone) 22b Was case referred to medical events and but not resulting in the underlying cause given in Part I. 22a Date of delivery 22b No 25	Page Page nent c		4 Donation 5 Other Specify: Parkwood Cemetery	3/27/2	007	Baltimor	e, Maryland
Physician Medical Examiner 22a. Part Effect the disease or complications that caused the east. Do not error that mode of lying, six in as calling or respiratory wheel, as consequence or condition resulting in death) Sequentially late conditions.	alti rmit epartn iport			-	-	D	T
Moduled Sequentially list conditions Condition resulting in death) Condition resulting in death Condition resultin	173		John John John John John John John John	ue Dun	dalk.	Maryland	111C.
Cardial disease Cardial di			failure. List only one cause on each line.	Salmac of Tespire	iory armst,	Street, The str	Detween Onset and
Sequentially list conditions, large	_				_		
The contribution of the cause of programmy and the contribution of the cause of death? The contribution of the cause of	Medium.		Concenital heart disease				
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Past 12 months? Past 12 months? Past 12 mon	60, ate be hysici e buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	у
296 Signature and title of certifier O.C.M.E. March 23, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Egistrar's Signature	587 extific	an/I	past 12 months?	c pregnancy		Month	Day Year
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296 Signature and title of certifier O.C.M.E. March 23, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Egistrar's Signature	COF law r has b	uple	M		performe	ed? death?	_
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296 Signature and title of certifier O.C.M.E. March 23, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Egistrar's Signature	D C nding th.	ion	1 X Natural 5 Pending (Month, Day, Year)	No			
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296 Signature and title of certifier O.C.M.E. March 23, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Egistrar's Signature	Div	erti	4 Homicide determined (Specify)	Of Of	10WII, Stat	e)	
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Baltimore, Maryland 21215-0036

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1 Yes 2 No 3 Probably 4 200 24a. Was an autopsy performed? performed? performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 1 Pending 2 Accident 3 Suicide 4 Homicide hysician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a	2 Fetal o	death 3		y					
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		(Check only 2 Medical one)	Examiner: On the basis of and manner st	f examination	ledge, death on and/or inv	estigation, in my	opinion, death occu	e, and due to the curred at the time, d	ause(s) and mannate and place, an	ner as stated. d due to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Σ	29b. Signature and title of certifier	- 1			29c. Licens	e number	2			
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ate 31. Date filed (Month, Day, Year) 32. Ristar's Signature							T HOS PI	TAL S	5401 02	O COURT RIAL	

07-02027 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death Madical Examiner Zachary Wade Clevenger 1253 hrs March 15, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore N/A 5. Social Security Number **Funeral** Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Days Hours 213-77-1769 1X M 2 F 3 12 2006 Country) MD Usual Residence of Decedent any 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ust be notified at once. N/A MD Baltimore 1 X Yes 2 No death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 601 Baltic Avenue 21225 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Drigin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 X Never Married Armed Forces? 2 White, etc. 0 Yes Widowed Divorced If Yes, Give Year 1 Yes 2X No specify: White Specify. þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene aut: If item 27 is marked other than "I or other traumatic event, the Medical E College (1-4 or 5+ Baltimore, MD 21215-0036 N/A N/A Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Bradley Clevenger Joni Schmincke 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Baltic Ave., Joni Schmincke - Mother Baltimore, MD 21225 20a. Method of Disposition

Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State West Arundel 3-22-2007 Odenton, MD Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 **Physician** Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Sudden unexplained death in infancy (SUDI) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and Physician/Medical X UNPENDED attending physician or use as the burial perME, g868, 6/11/07 TT Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Month Day Year past 12 months? 2 Pregnant at time of death 5 The law requires that the death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 23e. Did tobacco use contribute to the cause of death? ≥ Records, P. 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate h Yes 2 ✓ Yes To the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ 1 / Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 After this ဥ 1 V Yes Residence 6 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d Describe how injury occurred Certification: Natural 1 Yes 2 X No death . the Fnd 3/14/2007 Fnd 4:30 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 filled in Suicide 6 X Could not be 601° Baltic Ave. Baltimore, MD determined (Specify) Fo the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E March 16, 2007 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:08 P MARCH 2007 SIGMUND COHEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE TOWSON If Under 1 Year HOSPICE OF BALTIMORE GILCHRIST CTR Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 M 2 □ F 02/06/1916 MD 91 217-26-9573 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Lygiene. Ir portant: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at other. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No BALTIMORE TOWSON Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 U.S.A. 8415 BELLONA LANE #602 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1∐Yes 2M∏No Baltimore, Maryland 21215-0036 Specify WHITE ģ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) DENTISTRY DENTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STEINBERG COHEN REBECCA LOUIS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8415 BELLONA LANE #602 - TOWSON, MD 21204 LOUISE COHEN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/25/2007 REISTERSTOWN, MD BALTIMORE HEBREW 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Right Physician /Medical Due o (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause of en in Part I. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1□ Yes or Attending Physician: funeral director, 26. Place of Death | Check only one) 25. Was case referred to medical Be examiner? 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 XOther (Specify) #C6PLCE Other: 2□ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this Bd. Describe how injury occurred entering.
Tell in hallway entering.
Nouse then a mar Fall & inside 28c. Injury at Work? 28a. Date of Injury 28b. Time of 27. Manner of Death Natural 2 Accident (Month, Day 5 Pending investigation afternoon 1 ☐ Yes 07 nouse the 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) \$415 Bellonalare/Towson 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Towson MD home within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Towsartown Blud kendall R. Paulkner MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

		For State Ragistrar	State of Marylar			of Health and of Death		ene2	07	09560
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Examin	er	4a Fecility Name (If not institution, give Bel AIR Health + 5. Social Security Number 6. Se:	- Rehab Ce	NTER last birthday)	If Under 1		8 Date of Birth	Ha	y of Death 3 r fo 9. Birtho	
Funeral Director			RM 2□E	69 Yrs.	Months D	ays Hours Min	(Month, Day, 7 – 30 – 1	937	Vir	lace (State or Foreign try) 'ginia
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within 24 hours aftar death. To the Funeral Director: completely filled in by the f.	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinates	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the estigation, in	he time, date and plac my opinion, death occ	e, and due to the car urred at the time, da	use(s) and m te and place	anner as st , and due to	ated. the cause(s)
within 2, complete	2	29b. Signature and title of certifier	-de orp			cense number 00617		d. Date sign APCH,		
(30. Name and address of person who co	ompleted cause of death (Itel WVAH), 9,66 F	т 23a) (Туре, F PHILADE:	Drint)					
Sta Registr		31. Date filed (Month, Day-Year)	32. Registrar's Sign		P					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5.8 per fb 9866 4-6-07 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician Winfred Cox 12:46 A M 03 26 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Hospice Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 2382 213-60-2282 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min 1**X** M 2□ F Months Days Hours Yrs. 07/29/1954 MD 52 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f shov must be notified at Baltimore 1 XYes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 4232 Sheldon Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ā No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after did bepartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or item important: If item 27 is marked other than "natural", or item and injury or other traumatic event, the Medical Examiner once. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify African American Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St. Agnes Hospital 11 laundry technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winfred E. Cox, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 4232 Sheldon Avenue; Baltimore, Maryland 21206 Vivian Cox / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 03/30/2007 Baltimore, Maryland Sacre Heart of Jesus 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1515 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) a I Inknown 9 Unknown signed by ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Completed by runt ducerte 4 nd SMYC 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy performed? 1 Yes 2 No or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSO (1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58303 march 26 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles So Towson AMON I CHAPLES MO 6701 \sim 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 7 2007 Registrar

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James Otis Caldwe	Otate of Maryland / Department of Fleath and Mental Flyglene	0956
Physician/	Registrar Certificate of Death Reg. No.	3 Time of Death
Medical Examine		1718 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stone Chapel Road, South of Medford Road Westminster Carroll	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth	hplace (State or
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To To Com	and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Mon	th, Day, Year)
	Thedre M. F. Jr., mis. O.C.M.E. March 21, 2007	
り	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1etz 2007 Ann exesa Mareh 25 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore NIA HOSPITAL SECOUYS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Man (and. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F 44 218-78-904 07 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Baltionore MB Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 101 Funeral . Was Decedent Ever in U.S. Armed Forces?

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Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2.27No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) oortant; if item 27 is marked other than Injury or other traumatic Unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be rance amono 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 875 Mother gemere Mamona () 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐Removal from State 22. Name and Address of Facility 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 7173 Chesico ide Baltom Hone 1711 tuntal Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1490 Li Var **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** imhosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed alcohol abus attending physician and Due to (or as a consequence of) O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 HUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division or Vital Records, 2 No 3 Probably 4 Unknown 1) Nummio Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 🔼 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 3 DOA 2 No 1 🛣 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes Certification: To this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 🛛 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 251 s of person who completed cause of death (Item 23a) (Type, Print) and addr BUN SECOURS HOSPITAL, 2000 West Baltomore Street, Bultomore, Moryland, 21223

State Registrar

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31. Date filed (Month, Day, Year)

MAR 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No:--3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 06:19 P.M **Physician** WILLIAM DEAN 21, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD **JARRETTSVILLE JARRETTSVILLE** PIKE 3709 8. Date of Birth (Month, Day, Year) 05-19-1954 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days XX M 2□ F PENNSYLVANIA 52 151-50-1908 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or Iteme 23s or 28s-f show street sust be notified at 1 Yes 2 No JARRETTSVILLE MD. HARFORD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 21084 PIKE 3709 **JARRETTSVILLE** Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Depertment of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or tiles any injury or other traumatic event, the Medical Examinations. 1 Never Married X Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) YEARS Elementary/Secondary (0-12) **EMPLOYED** SELF CATERER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RUBEY ELIZABETH W. DEAN THOMAS ALAN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (WIFE) 11 BELLCLARE CIRCLE, SPARKS, MARYLAND, 21052 CONSTANCE DEAN Date 20a. Method of Disposition
1 ☐ Burial X ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of TOWSON, MARYLAND, 21204 HILLTOP SERVICE CORP, 03-23-2007 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD (R. G. RUTH) RUCK TOWSON FUNERAL HOME, INC. & Ku TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiovasu lar disease Physician Htheroscleratio /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Dav 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 2**X X**Vo 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes **XX**No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner?

XX Yes 2.□ No 26. Place of Death (Check only one) Medical CertIfication: To Be Other: 4 Nursing Home XX Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After X Natural 5 Pending investigation s after death.

I Director: Aft
of in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospital or Al within 24 hours after of To the Funerel Direc 4 - Homicide XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Diemich Mo MARCH 22, 2007 D0057257 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIETRICH, M.D., 3346 PAPER MILL ROAD, PNOENIX, MARYLAND, 21131 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

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Division or Vital Records, P.O. Box 68760,	the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.	the Funeral Director: After this certificate has been signed by the attending physician and

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			State Registrar		Ce	ertificate of L	Death	2. Date of De	Reg. No. 2	07 09565
PI	hysicia	an	1. Decedent's Name (First, Middle, Last) Clara Rose Dziewanowski				1	Month March	Day	Year 007 11:16 P.
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		To Be	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpat	ient 3 DOA Oth	or:		idence 6 Othe	er (Specify) HOSAICE
O for the second	Arter tr uneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	/ Wor	ry at rk? Yes 2 □ No	28d. Describe	how injury occurre	ed
IVISION r Attending ter death.	y the f	ficati	2 Accident investigation 3 Suicide 6 Could not be determined	e 280 Place of injury - At	t home, farm,		1165 2 110	28f. Location (Street and Number	er or Rural Route Number,
DIV safter	al Dire ed in b	Certification:	4 Homicide	building, etc. (Spe	эспу)			City or 10	wn, State)	
Hospital	To the Funeral Director: After this completely filled in by the funeral directors.	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my k miner: On the basis of exam and manner stated.	knowledge, de ination and/or	ath occurred at the ti investigation, in my	ime, date and place, opinion, death occur	and due to the red at the time	cause(s) and ma , date and place, a	nner as stated. and due to the cause(s)
To the within 2	r o the comple	Med	29b. Signature and title of certifier	and marrier stated.		29c. Licens	se number		29d. Date signed	d (Month, Day, Year)
F > 1			Dandall	_Rtdell	es	D25	5643		03/2	5/2007
(0			30. Name and address of person who	completed cause of death (I	tem 23a) (Typ	e, Print)	an ar.	A/R	alta M	D 21204
	Sta	ate	31. Date filed (Month, Day, Year)	32. Begistrar's Sig	gnature) we greet	- 011			0.001
F	Regist		MAR 2 7 2	007	H. A	berte				
DHMH 17	Rev 1/2	2001	eres of the same	Joseph .	7	RIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State C	of Maryland / Depa <i>Cer</i>	rtificate of Dea		Tygiei Reg. N	2007	09566
q.	Dhuaisi		1. Decedent's Name (First, Middle, Last)			2. Date o Month		ay Year	3. Time of Death
	Physicia Medio/		Nancy Lee	Dennis		Marc	h 20	2007	8:05 P M
	Examin	er	4a. Facility Name (If not institution, give street and nu.					lc. County of Death	1
			1611 Locust Street 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Un	der 24 Hrs. 8. Date o	Birth	n/a 9. Birth	place (State or Foreign
ì	Funeral Director		217-30-4632 1□ M 2页 F Usual Residence of Decedent	70 Yrs.	Months Days Hou		Day, Yea	Ir) Cou	ginia
	rland ow		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh ified a	tor	Maryland N/A		Baltimore				1 X Yes 2 □ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	I Director	10e. Street and Number 1611 Locust	Street	10f. Zip Code	21226		Citizen of What Cou USA	intry?
	death	Funeral	11. Marital Status 12. Was Dec	edent Ever in U.S. 13. V	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes o	No-	14. Race - Ameri Black, White	
215-0036	urs after al", or ite Examine	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 ☐ Widowed 4 X Divorced Year or D	2 No	1 ☐ Yes 2 No Spec			Canality and	ite
r C	72 ho natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during r DO NOT use retired)	most of working	16b.	Kind of Business/Ir	ndustry
Z	within ene. than "	mpl	Elementary/Secondary (0-12) College (1-40r 5+)		3	Ho	usewife &	Mother
7	filed w Hygie other ti	S	17. Father's Name (First, Middle, Last)	He	omemaker 18.M	other's Name (First, Mid			Hother
yiand	Mental F Merked of arked of	To Be		n Lee Hockada			lmma S		
Mar	and 2 shouk lealth and Me m 27 is mark her traumatik		19a. Informant's Name/Relationship (Type. Print) $Nancy \ L. \ Bloore \ \ ($		ng Address <i>(Street and Nu</i> 4 Lee Circle				
ē,	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Disposemetery, crer	sition (Name of matory or other place)	Date	20c.	Location - City or T	own, State
Ĕ	Pages ment of I ant: If its ury or o		4 ☐ Donation 5 ☐ Other (Specify)	Cedar Hil	ll Cemetery	3/26/07		ltimore,	Maryland
Baltimor	permit. Page Department of Important: if any Injury or once.		21. Signature of Funeral Service Licensee Kevi	IV	Name and Address of Fa AcCully-Polyi 237 E. Pataps	niak Funera Sco Ave B	1 Hom	ne, P.A.	1225–1856
ľ	`		23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on e	caused the death. Do not entreach line.	er the mode of dying, such	as cardiac or respirato	ry arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	lung concer					Onset and Death
2	/Medical Examiner		resulting in death) Due to	(or as a consequence of):					
	Lxummer	_	Sequentially list conditions, b.	(or as a consequence of):					
ī	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	(or as a consequence or).					
,	execunand and all-tra	Examiner	that initiated events c.	(or as a consequence of):					
00/00	fficate be executed g physician and as the burial-transit	edical	d						
T	ntifica ng ph		IF FEMALE:						
7. BOX	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	sician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, ou	nant at time of death 5 □	Ectopic pregnancy Other (specify)		=	23d. Date of deliv Month	very Day Year
ŗ	that the sd by detacl	Phy	Part II. Other significant conditions contributing to d	eath but not resulting in the ur	nderlying cause given in Pa	art I. 23e. [id tobacco	use contribute to	the cause of death?
Records,	equires een sign ould be	ted by				1	☐ Yes	2 No 3 Pro	bably 4 Unknown
S	e law r has be	Completed				a	vas an utopsy	prior to co	opsy findings available ompletion of cause of
	The	S				1 V	erformed?	death? No 1 ☐ Yes	2No
N I G	sician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1		Othor	lace of Death (Check of			
5	Physer this eral di	2	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatien of Injury 28b. Time of	T 3 DOA 4	Nursing Home 5 F		6 ∐Other (Speci jury occurred	fty)
VISION	nding th. r: Afte e fune	tior	1 Natural 5 □ Pending (Mon 2 □ Accident investigation	oth, Day Year) Injury	M 1 ☐ Yes 2	2□No			
ZIVIS	or Atter	Certification:	3 Suicide 6 Could not be determined 28e. Place build	e of injury - At home, farm, streing, etc. (Specify)	eet, factory, office	28f. Location City of	n (Street Town, Sta	and Number or Rui ate)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the band man						
	To the within To the	Me	29b. Signature and title of certifier		29c. License numb	er	29d. D	Date signed (Month	, Day, Year)
			1		D409	£9	<u> </u>	man 21	,2007
	3		29b. Signature and title of certifier 30. Name and address of person who completed causes 300 / 5. Han v. M. 31. Date filed (Month, Day, Year)	se of death (Item 23a) (Type, I	Print) M d 2	225 7	ACK	HODE	s M.D.
	Sta	te	31. Date filed (Month, Day, Year) 34. F	Registrar's Signature	iles		, -,		
	Registr		MAR 2 7 2007	Site of Signal	- Green				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Year. Diffence **Physician** 19V Or 2007 /Medical 4c. County of Deeth 4b. City, Town, or Location of Deeth Fecility Neme (If not institution, give street end number Examiner House Nuvsin Howard Colums If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2□ F Director 82 220.22.4351 October 7, 1924 Maryland Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Manylend Depertment of Health end Mental Hygiene. Important: If tem 23 a or 28e4 show any Inportant: If tem 23 a or 28e4 show any Injury or other traumatic event, the Medical Exertment and the political at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director Maryland Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 5400 Vantage Point Road 21044 Funeral U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Maritel Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) at home homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Walter R. Gilbert Pearl Irene Zeller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2650 Bethany Lane Ellicott City, Maryland 21042 Mr. David C. Diffendal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/27/2007 Meadow Branch Cemetery 22. Name and Address of Ficility Westminster, Maryland 21. Signature of Funeral Service Licensee Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MC053 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Qu MaL Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yee 2 No 3 ☐ Probably 4 ☐ Unknown edicai Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 des 2 de 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, efter death.

Director: After this certificate filled in by within 24 hours efter To the Funeral Dire completely To the

3altimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

Karlow 31. Date filed (Month, Day, Year)

4 Homicide

(Check only

29b. Signeture and title of certified

29a. Certifier

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

0801 32. Registrar's Signature

HICKOV

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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	10 Pi	ч.	For State	State of Maryland	•	nent of He <i>cate of D</i>				000 09	560
			Registrar 1. Decedent's Name (First, Middle, Last)		Certiii	cate of D	eaui	2. Date of Deat	eg. No. 20		e of Death
п	Physici	an	H: O Miller		2	VAN		Month March	Day	Year	47 M
The second	/Medio		4a. Facility Name (If not institution, give stre	et and number)	4b.	City, Town, or L	ocation of Death	100 01	4c. County		
fair .	LAdiiii		John Hookins Bay	view Medical	Center P	a ltimo	re Cita	1			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la:	Mo	Inder 1 Year Inths Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day,	Year)	Birthplace (Sta Country)	ate or Foreign
l.	Director	1	120-64-7484 USual Residence of Decedent	48	Yrs.			5-27	-58	Mary	land
	land ow		10a. State 10b. County	10c. City,	Town or Locatio	n				1.75	e City Limits
	a-f sh ified	ctor	MD	\mathcal{B}	altir	nore	J			1,2	es 2□No
	ith the	Dire	10e. Street and Number		11	of, Zip Code	2 12	1	0g. Citizen of N	What Country?	
	hours after death with the Maryland tural", or Items 23a or 28a-f show MExaminer must be notified at	Funeral Director	3724 Jon Vi	ew Aver	Jue 12 Was	Donadant of Hin	panic Origin? (Spe	sifu Van ar Na	14 Bac	SA ce - American India	n.
	ter de Item	un-	11. Marital Status 1 ☐ Never Married 2 Married 12.	Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No	If Yes	s, specify Cuban,	, Mexican, Puerto I	Rican, etc.)		ck, White, etc.	
920	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	res 2 Alo	Specify:		Specify	Blac	K
5-0036	72 ho natur dicail	Completed	15. Decedent's Educati (Specify only highest grade co		(Give kind		ion ring most of working		16b. Kind of B	usiness/Industry	
2121	vithin ne. han "	mple	Elementa (Secondary (0-12)	College (1-4or 5+)	Life. DO N	OT use retired)	too		Bolt	more	Gtu
	illed v Hygie ther t nt, th	ပိ	17. Father's Name (First, Middle, Last)		1110	1191	8. Mother's Name	(First, Middle, I	Maiden Surnan		J
and	d be t ental ked o c eve	To Be	1.D. FLOOR			-	Doni	s St	1105	5	
Maryland	shoul ind M i marl umati	F	19a. Informant's Name/Relationship (Type.	Print)	19b. Mailing Ad	dress (Street an	nd Number or Rura	l Route Number	City or Town,	State, Zip Code)	
	ages 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Deborah Frans	(WiFe)	3724	Bony	11ew F	ve B	alto.	MD 21	213
Baltimore	permit. Pages 1 a Department of Hes Important: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	COL	ce of Disposition metery, cremato	(Name of ry or other place)	3/2	107		- City or Town, Stat	
Ē	E TE L		4 □ Donation 5 □ Other (Specify)		nmow	rt Gren	natory		3017	incore,	MD
Ball	permit. Pa Departmer Important: any injury		21. Signature of Funeral Service Licensee	no1363	Ya	ughe (of Cheen	Tu Tu	vera	incore, Service 21210	25
			23a. Parti. Enter the disease, or complicat shock, or heart failure. List only one			e mode of dying,		BAL	KO LA	Approx	imate
	Dhusisian		Immediate Cause (Final	cause on each line.	C 2	Lock	1			Onset	Between and Death
7	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):	AI CPI	1 Car	inom	M	7	055
	Examiner		b b								
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):						
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687	w requires that the death certificate been signed by the attending physishould be detached for use as the	Physician/Medical	d								
Box (n certii nding use a	n/M	IF FEMALE: 23c.	. If yes, outcome pf pregnan					23d. Da	te of delivery	
-	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		opic pregnancy er <i>(specify)</i>			Me	onth Day	Year
P.0	at the by th	hys	9 ☐ Unknown					no- Dida-		tribute to the cause	of dooth?
	requires that the een signed by th nould be detache	by F	Part II. Other significant conditions contril	buting to death but not result	ing in the under	ying cause given	in Part I.	1 🗆 Y		3 ☐ Probably	
oro	requi	Completed by	pheumonia	·							
3ec	The law ate has be	mple						24a. Was a autops	SV	Were autopsy find prior to completion death?	of cause of
Vital Records,	n: Th ficate or, pag		25. Was case referred to medical				26. Place of Death		2 No	1 res 2 No	
	Physician: this certific	To Be	ovaminor?	pital: 1 Dinpatient 2 □ E	R/Outpatient 3	Other				ner (Specify)	
Division or	g Phy ter thi neral o	n: T		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury		28d. Describe he			
ior	Attending r death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation			/ 1 □ Y	es 2□No				
Νį	after de after de I Directe d in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	 Place of injury - At hom building, etc. (Specify) 	ne, farm, street,	factory, office	;	28f. Location (Si City or Town	reet and Numi n, State)	ber or Rural Route	Number,
Ω	Hospital of the hours af Funeral Discharan Discharal Discharal Discharal Discharal Discharal Discharan Discharal Discharal Discharan Dis	Cel	29a, Certifier 1 CertifyIng Physic	ian: To the best of my know	ledge death oc	urred at the time	e date and place	and due to the c	ause(s) and m	anner as stated	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Examiner one)	r: On the basis of examination and manner stated.	on and/or invest	gation, in my opi	inion, death occur	ed at the time, o	ate and place,	and due to the ca	use(s)
	To the within 2 To the comple	Me	29b. Signature and title of cortifier	N LA		29c. License	number) 2	9d. Date signe	ed (Month, Day, Ye	ar)
			> Wywea	VANTO		1	7407		3/2	-8/0	
	13		30) Name and address of person who comp	pleted cause of death (Item			0		94.0		
		X	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	N. W	ille St	Balti	nore,	MURIZ	287	
	Sta Regista		MAR 2 9 2007	Concess At As	parte						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:00 AM 0 1,20 5 /Medical (If not institution, give treet and number 4b. City, Town, or Location of Death 4c. County of Death Examiner towa tate or Foreian vrs. last birthday **Funeral** Months Days Hours Min 1 □ M 2 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD 1 ☐ Yes 2 ¥No Funeral Director 10g. Citizen of What Country? 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e kind of work done during DO NOT use polired) Elementary/Se ary (0-12) College (1-4or 5+) 17 Eather's Name (First Middle, Last) Be 19b. Mailing Address (Street and Number ral Route Number. City or Town, State, Zip Code) 1 Burial 2 □ Cremation 3 Removal from State leud 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig tre Va ile. 23a. Part1. Enter the shock, or h Approximate Interval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Immediate Cause (Final Physician ANCHESTIC Mon 176 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any 1-2 ling to in 1.2 list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed funeral director, page 2 should be detached for use as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. signed by the attending physician by Physician/Medical IF FEMALE It yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2. No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Tes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) Medical Certification: To After this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pateur AL Colembin, MD 21.74 [101] . Registrar's Signature 31. Date filed (Month, Day, Year) State 7 Registrar 2007

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

07-02242	
Charles Foard	

Charles Foard	State of Maryland / Department of 1-For State Certificate of		ygiene Reg. No.	2007 0957
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Medical Examiner			Month Day March 22, 2007	1612 1115
	Tal. I don't y raine (ii not included on give one or	4b. City, Town, or Location of Death Baltimore	4c. Co	ounty of Death
	Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8. Date of Birth(MM/DD/	N/A YYYY) 9. Birthplace (State or
Funeral Director	217-50-6690 (XXM 2 F 58 Yrs	Months Days Hours Min.		Foreign
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	tion		10d. Inside City Limits
8 4	Manual and Daltimore Dundal	k		1 Yes 2 No
the Maryland a or 28a-f show tified at once. Director	10e. Street and Number	10f. Zip Code	10g. Citizen	of What Country?
the M	8401 Kavanagh Road	21222	Unite	ed States
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once. Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Sp		Race - American Indian, Black, White, etc.
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036 ithin 7 ne. r than r die	· 11 years Reta	il Stockman		ail Grocery
5-0 lied w Hygie othe Co			e (First, Middle, Maiden Sur	
, MD 21215-0036 and 2 should be filed within 7 teath and Mental Hygiene. tem 27 is marked other than traumatic event, the Media To Be Comple	Paul William Foard, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	Alberta Ig Address (Street and Number or	Mary Hinkle	or Town, State, Zin Code)
O ∜ B 5 # [_	1005		Delmar. Marv	
ore, MEss I and 2 s of Health an If item 27	20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery,		ation - City or Town, State
imore, MD 2121: Pages I and 2 should be fil ment of Health and Mental I tant: If item 27 is marked or other traumatic event, To Be	1 Burial 2 Cremation 3 Removal from State crematory or of a Donation 5 X Other Specify: Entombment Dulaney		3/29/2007 1	imonium, Marvland
Baltimore, MI permit. Pages I and 2: Department of Health a Important: If item 27 injury or other traum.	21. Signature of Funeral Service Licensee 22.	Name and Address of Facility		174
Per Per I	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	ouda-Ruck Funeral	. Home of Dun Dundalk Ma	ryland 21222
Physician /Medical	failure. List only one cause on each line.		or respiratory arrest, shock,	or leart Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Occlusive Pulmonary Thromboem Due to (or as a consequence of):	bolism		Death
	Left leg deep venous thrombosis			
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	***		
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	vv		
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60, ate be executed hysician and e burial - transit	UNPENDED AMENDED			
ficate be g physicisthe burit	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic pregn		Date of delivery onth Day Year
Box 6871 e death certifice the attending pled for use as the	past 12 months? 1 Live birth 2 F 4 Pregnant at time of 5 C	Other (Specify)		,
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P.O. sthat the greed by detach		underlying cause given in Part I.		No 3 Probably 4 V Unknown
atuires en sign			24a. Was an	24b. Were autopsy findings available
Corclaw relaw		autopsy performed?	prior to completion of cause of death?	
tal Records, cian: The law requires certificate has been signer, page 2 should be Be Completed		20 Dinner of Death (Oheal	1 Yes 2 N	1 Yes 2 No
ician:	25. Was case referred to medical examiner?	26.Place of Death (Check	ing Home 5 Residence	e 6 Other:
Division of Vital Records, P.O. tal or attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by Partification:	1 V Yes 2 No The Injury 28h Time of		28d. Describe how injury	occurred
on on carrier ath. Prix African tion	1 Natural 5 Pending Feb 14, 2007 ear) 0000 hrs	1 ✓ Yes 2 No	Subject torn cartilag	ge while shoveling snow at
VISION Atthemed Procession of the Contractor of	2 Accident Investigation 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (Street and or Town, State)	Number or Rural Route Number, City
Division o Spital or Attending spital or Attending sours after death. neral Director: After filled in by the fune Certification:	4 Homicide determined (Specify) Retail Store		2805 N. Point Road, D	
the Ho hin 24 h the Fu npletely		urred at the time, date and place, an ation, in my opinion, death occurred	d due to the cause(s) and r at the time, date and place	manner as stated. s, and due to the cause(s)
To So De Marie	29b. Signature and title of certifier	29c. License number		ite signed (Month, Day, Year)
× 4	unes	O.C.M.E.	March	n 24, 2007
K	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2120	01	
State	31. Date filed (Month, Day, Year) Registrar's Signature	R. J		
Registra	MAR 2 7 2007 Description 10. 1990			

State of Maryland / Department of Health and Mental Hygierie

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Fernandez 2007 10:30aM 03 24 Berkley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min 8. Date of Birth (Month, Day, Year) 05 22 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sax **Funeral** 1 □ M 2 🕅 F Trinidad 45 61 217**-**69-9126 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Worle permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 le marked other than "natural", or iteme 23a or 28a-1 ehow any Injury or other traumatic event, the Macical Examinar must be notified at once. 1 XYes 2 No Director Baltimore NA MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 Trinidad 3113 Bancroft Road Apt A Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ②☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hotel Housekeeping na 9th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown Be Gemma Wilson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) A, Balto, Md 21215 3107 Brancroft Road Apt Darrel Fernandez-Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Metro Crematory Inc 3/31/07 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FRUICAL /Medical Due to (or as a consequence of) 3 FEARS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No ģ 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No certificete To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Wother (Specify) 1 Tyes 2 PNo ဥ Director: After this tin by the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certify D0026327 30. Name and address of pe ison who completed cause of death (Item 23a) (Type, Print) AMPFIDE, COUMBIA MD 6114 trar's Signature State Registrar 2007

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James K. Flemm	-	Sr. S	tate of M	laryland /		tment of			Menta	al Hy		2	nn.	1 1957
Dhysisis		Registrar 1. Decedent's Name (First, Mide	tle Last)		Certi	ilicate oi	Deali			12	Reg 2. Date of Death	g. No 🛴	. U U	3 Time of Death
Physicia Medical Examir		James K. Flemin										Day 1	Year	1715 hrs
		4a. Facility Name (if not instituti	on, give stree	and number)		[4b. City, To	wn, or Lo	ocation of				nty of Death	· -
		1026 North Bentalou	Street				Baltim	ore						_
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. las	t birthday)	If Under Months		If Under :	24Hrs. Min.	8. Date of Birth	(MM/DD/YY	(YY) 9. Birt Foreig	hplace (State or n
Director		212-42-3656	1 X M 2	:F		63 Yrs		Days	Hours	IVIII I.	06/30/1	943		untry) MD
ž		Usual Residence of Decedent 10a. State 10b. County			10c City T	own or Locati	ion							10d Inside City Limits
Ow any		MD 100. County			100. 019, 1									1 X Yes 2 No
ryland ra-f sh t once	홝	10e. Street and Number	-				Baltim				10	g. Citizen of	What Cour	ntry?
he Maryland or 28a-f show : iffed at once.	Director	1026 North Benta	alou Str	eet					1216				ī	JSA
with the sas 23a		11. Marital Status		Vas Decedent I	Ever in U.S			t of Hispa	anic Origin		cify Yes or No-		ace - Ameri	can Indian, Black,
death r iten	Funeral	1 Never Married 2	lailleu -	rmed Forces?	X No	If Y	es, specify	Cuban, I	Mexican, P	uerto R	ican, etc.)		hite, etc. Africar	American
after al", o			vorced if Yes, or Dat	es:			Yes 2				_			
hours natur Exam		15. Decedent's Education (Sp				16a. Deceden during m	it's Usual C ost of work					16b. Kind of	Business/l	ndustry
36 in 72 han "	bet	Elementary/Secondary (0-12 12) Co	ollege (1-4 or 5	+)		bari	her				barl	er sho	
5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name (First, Middle	e, Last)				Daz		3.Mother's	Name (I	First, Middle, M			<u> </u>
215 be file ntal Hy rked o	Be		am Flem	ing							Ethel Wor	sley		
21, ould b d Men d Men d mar	庐	19a. Informant's Name/Relation									ral Route Num			
MD d 2 sho th and th and n 27 is		James K. Fleming	g, Jr. /	Son							t; Baltin			21216 Town, State
ore, slan of Hea If iter		20a. Method of Disposition 1 X Burial 2 Crematic	in 3 Re	moval from Sta		ace of Dispos ematory or otl		e of ceme	etery,		Date	20c. Locatio	on - City or	Town, State
imore, Pages 1 a nent of He tant: If ite		4 Donation 5 Other	Specify:		Woo	dlawn (-		03/3	1/2007	Wood1a	awn, Ma	ryland
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	-	23a. Part I. Enter the disease, of	or complication	ns that caused	the death. [Do not enter t	538 N. he mode of	Gilmo	or Str	eet;	Baltimo	re. Mar	yland heart	21217 Approximate Interval
Physician /Medical		failure. List only one caus	e on each line	act Gunsho				, ,						Between Onset and Death
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and the second		Sequentially list conditions,	b									_		
	ine	if any, leading to immediate cause. Enter Underlying Caus		(or as a conse	quence of):	:								
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cia cia	edical	UNPENDED		NDED								Land Date	o of dolivon	
D.O. Box 68760, that the death certificate bent by the attending physic detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in		Live birth	ne of pregna		etal death	3	Ectopic p	oregnan	су	Montl	e of deliver h [Day Year
X 6	sicia	past 12 months?	nknown 4	Pregnant at	time of dea	th = =	ther (Spec	ify)						
Box he death of the atter	Phys	Part II. Other significant cond	9 [Unknown	but not ro	nulting in the	undorlying	course di	von in Part	-1	23e Did to	bacco use co	ontribute to	the cause of death?
Division of Vital Records, P.O. Box 68760 within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate I to the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	b	Part II. Other significant cond	idons cond	butting to deatr	Duthotres	salting in the t	undenyng	cause gi	VGIT III T CIT					pably 4 Unknown
ts, land	ted										24a. Was a	an 24		topsy findings available
Cord law re has be	ompleted										autop: perfor	med?	death?	completion of cause of
Re The	ပေ	05.14(al I				-	6 Place	of Death (C	heck or		2 V No	1 Ye	es 2 No
ltal sician is certi irecto	۵ij	25. Was case referred to medic examiner?	Hospita	al: 1 Inpatie	nt 2 l	ER/Outpatient			Whor -			Residence	6 Othe	r: Scene
n of V ling Phy: After thi funeral d	<u>۱.</u>	1 ✓ Yes 2 No 27. Manner of Death	2	Ba Date of Inju (Month, Day,Y		28b. Time of		28c. Injury	at Work?		28d. Describe h		curred	
ion tendin eath.	tion		liding ,	OUND: Day, 1 Mar 22, 2007		FOUND: 1650 hrs		1 Y	es 2 🗸 l	No	Subject shot	seir		
Division of Vital Records, tal or Attending Physician: The law requirers after death. "al Director: After this certificate has been sited in by the fumeral director, page 2 should I	ertificati			8e. Place of In			et, factory,	office bu	uilding, etc.					ral Route Number, City
Divisi Hospital or Att 24 hours after de Funeral Direct	Cert	4 Homicide		Specify) Sin	<u> </u>						or Town, S 026 North Be			
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		(0),00,00,00	Physician: T	o the best of m	y knowledg	e, death occu	rred at the	time, dat	te and place death occi	e, and ourred at	due to the caus the time, date	e(s) and mar and place, a	nner as stat nd due to th	ed e cause(s)
To the within To the comple	Medical	29b. Signature and title of cert	and_r	nanner stated	duoir di			License			,			nth, Day, Year)
	2		1/10	00-				O.C.N				March 2		
		30. Name and address of pers	on who comple	eted cause of o	leath (Item)	23a)						L		
10				edical Exar		111 Penn	Street, I	Baltimo	re, MD	21201				
	tate			32. Registra	r's Signatur	re	4 >-		_					
Regist	trar	BARD 9 7	2007	1 20 0	ALO.	Flores	. 0							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 22 GREEN Physician March CLARENCE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Johns Hopkins Bayview Medical Center If Under 24 Hrs If Under 1 Year Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Min Months Hours 1 X M 2 □ F JUN. 20, 1926 80 Director 217-20-3859 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21239 Funeral 1909 E. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 9TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANCES HALL ပ CLARENCE FAX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4638 MARBOTTAL RD., BALTIMORE, MD SHIRLEY MORRISON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 11501 GARRISON FOREST 1 ■ Bunal 2 □ Cremation 3 □ Removal from State

Physician /Medical Examiner

After this within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

-	4 Donation 5 Dother (Specify)	GARR'	ISON FO	DREST 03/28	3/2007	OWINGS MILL	S, MD 21117
	21. Signature of Funeral Service Licens		22. Name	and Address of Facility WES	SLEY CHA	VIS. JR. FN	RI. HM.
	1/bles	Man As	200	7_09 EASTERN A	VE. BA	TITTMORE, MD	21231
	Immediate Cause (Final	lications that caused the death. Do not not cause on each line.	ot enter the m	ode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	resulting in death)	Due to (or as a consequence o	f):	7	33 2	9110101110	2 days
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	f):				
	22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BAI/TIMORE, MD 21231 23a. Pfin. Enter the dispress, or complications that cycled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, the mode of dying, such as cardiac or respiratory arrest, above, and the mode of dying, such as cardiac or respiratory arrest, above, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of delivery. 23d. Date of delivery 23d. Date of delivery						
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	_		the underlying	g cause given in Part I.			S. 2
Completed by	()				auto	psy prior to prior to death?	completion of cause of
Bec				26. Place of Dea	ath (Check only o	one)	
ToB	examiner? 1 Tes 2 No	Hospital: inpatient 2 ☐ ER/Out	patient 3	DOA Other: 4 Nursing H	łome 5□ Resi	dence 6 □Other (Spe	cify)
	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. T	ime of njury	28c. Injury at Work?	28d. Describe	how injury occurred	
Certification:		28e. Place of injury - At home, far building, etc. (Specify)	m, street, fact	ory, office	28f. Location (City or To	Street and Number or Rown, State)	ural Route Number,
edical ((Check only 2 Medical Exam	niner: On the basis of examination and	, death occurr d/or investigat	ed at the time, date and place ion, in my opinion, death occu	e, and due to the urred at the time,	cause(s) and manner as date and place, and du	s stated. e to the cause(s)
Me	29b. Signature and title of certifier	~		Res - 000		29d. Date signed (Mon.) Morch 2	

2:40 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 No

2007

Black, White, etc

21239

State Registrar 31. Date filed (Month, Day, Year)

DR. SUNIL KARHADKAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins BMC 4940 Eastern Avenue, Baltimore 21224 32. Registrar's Signature even & sports

State of Maryland / Department of Health and Mental Hygiene
1-For State Amend #20b&c per FH G866 4/18/07 Death

Registrar Doris Garcia Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Deat Physician/ GAYCI Year 1559 hrs Medical Examiner March 24, 2007 DOMIS 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Cheverly Prince Georges Hospital Center Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Months Days Hours Director 56 0828 Country) / М Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location RONX 1 Yes 2 No 23a or 28a-f show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Numbe 10f Zip Code Funeral 14 Race - American Indian, Black Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes Specify: WhitE Divorced If Yes, Give Year Yes 2 No specify: Pi E fa RICAN 2 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) nt of Health and Mental Hygiene
nt: If item 27 is marked other th
other traumatic event, the Medi 18.Mother's Name (First, Middle, Maiden Surname 17, Father's Name (First, Middle, Last) BARTOLOM Be 19a. Informant's Name/Relationship (Type, Print) HU4B AND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVE BRONX W.11 : Am MAI 6ARCIA 20c. Location - City or Bronx, N Y. Date UNK 20a Method of Disposition Burial 2 Cremation 3 Removal from State 3/30/2007 rant: Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service License Ph. 1119 E. OLIVER ST BALLEMA Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death Multiple injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical ing physician as the burial -X UNPENDED AMENDED, 27, 28a-f, perME, g866, 4/11/2007 TT Box 68760 23d Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed' ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Division of Vital Other₄ Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this 1 🗸 Yes Certification: To 28c. Injury at Work? 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending subject driver of vehicle in motor Natural Yes 2X No Pending vehicle accident FNd 3/24/2007 Fnd 3:08 pm 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12500 Kavanaugh Ln. & Kembridge Rd. Bowie, MD 28e, Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined (Specify) roadway Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E March 25, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Kathleen B. Goodson March 23, 2007 6:20 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7708 Beekay Road Edgemere Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F Director 16, 1957 220-68-0463 Maryland Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7708 Beekay Road Funeral 21219 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify <u></u> 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) +1Computer Operator Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise Helen Laubaugh Steve Barnecki ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21219 7708 Beekay Road <u>Gerard Goodson</u> (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery 3/27/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Avenue Dundalk, Maryland 23a. Part1. For the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TASTATIC WEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an cate has b autopsy performed Yes 2 certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No ျ 2 ER/Outpatient 3□ DOA this 5 A Residence 6 □Other (Specify) 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 5 Pending investigation Injury n 24 hours and, the Funeral Director; Af 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

- (COUNT FARMER SI STEPPEN

pae phin

Phil

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUERBAC

ORIGINAL

314, Boltimore, MO 21237

			1- For State Registrar	e of Maryland / Dep	partment of Health and Nartificate of Death	Mental Hygi		09577
	Physic /Med		1. Decedent's Name (First, Middle, Last) Paul Charles Grado			2. Date of Death Mar Ch 24,		3. Time of Death 2:15 A. M
	Exami	ner	4a. Facility Name (If not institution, give street and 6410 Everall Avenue		4b. City, Town, or Location of Death Baltimore		4c. County of Death	L
The state of the s	Funeral Director		5. Social Security Number 205-10-4870 Usual Residence of Decedent 6. Sex 1 🕅 M 2	F 90 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) February	(ear) 9. Birthpl Coun Penn	ace (State or Foreign try) Sylvania
	Maryland a-f show ified at	tor	10a. State 10b. County Maryland N/A	10c. City, Town or L Balti			10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 6410 Everall Avenue		10f. Zip Code 21206		g. Citizen of What Count	ry?
9600	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show di*al Examiner must be notified at	by	1 Never Married 2 Married 1	Give no Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whi	etc.
21215-	within 72 hiene. Jene. Than "nat The Medira	Completed	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) Colleg	e (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) YEMAN	ing	b. Kind of Business/Ind	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any injury or other traumatic event, the Medikal. once.	To Be C	17. Father's Name (First, Middle, Last) Pellegrino Grado	10		e (First, Middle, Ma	Martin Mariet iden Surname)	ta
, Mar	s 1 and 2 sho of Health and I item 27 is ma other traums		19a. Informant's Name/Relationship (Type. Print) Dorothy Bellich/Companion		ng Address (Street and Number or Run			Code)
Baltimore,	Pages 1 Iment of Hi Iant: If iter		20a. Method of Disposition 1 [X]Burial 2 □ Cremation 3 □ Removal frequency 4 □ Donation 5 □ Other (Specify)	20h Place of Disno	osition (Name of	Date 20	c. Location - City or Tov 1timore Maryla	
Ball	permit. Depart Import any Inj		21. Signature of Funeral Service Licensee	tton 5.	2. Name and Address of Facility Copard J. Ruck Inc. 305 Harford Road Balt	imore Maryla	and 21214	- 11
	death certificate be executed Wedical Exam death certificate be executed Afor use as the burial-transit Afor use as the burial-transit	ical Examiner	Sequentially list conditions, Later to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):	1	Failur	1	Approximate interval Between Onset and Death
P.O. Box 6	t the	Physician/Med	in the nast 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery	ay Year
Records, F	res the	þ	Part II. Other significant conditions contributing to	death but not resulting in the ur	nderlying cause given in Part I.		co use contribute to the	,
Sec.	The law ate has b page 2 st	Completed				24a. Was an autopsy performed	prior to comp death?	y findings available pletion of cause of
	Physician: this certific ral director,	To Be		☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death Other: 4 Nursing Hon	(Check only one)	e 6 □Other (Specify)	
_	D 0 0	Certification:	1 Natural 5 Pending (M 2 Accident investigation 3 Suicide 6 Could not be	te of Injury 28b. Time of Injury 29c of Inju	28c. Injury at Work? M 1 Yes 2 No	8d. Describe how in	njury occurred	
מות			4 Homicide bui	ding, etc. (Specify)		City or Town, St	,	
	o me nos vithin 24 h o the Fur ompletely	Medical		basis of examination and/or invinner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurred 29c. License number	at the time, date	and place, and due to th	ne cause(s)
	10		My duey Lyng	PHYSICIAN	D5359c	M	Date signed (Month, Da	
0	Stat			0014 609	am Tind	BROADS	21205	
	Registra	٠	MAR 2 7 2007	registrar's Signature	will -			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** MARCH 2007 P **JEROME** GOODMAN 3:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 1 Year 1 If Under 24 Hrs. 3122 LUGINE AVENUE BALTIMORE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, lace (State or Foreign **Funeral** Days Hours Months 1**√** M 2□ F MD 215-09-9094 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 3122 LUGINE AVENUE 21207 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any lipiny or other traumatic event, the Medical Eyamina. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🏋 No If Yes, Give 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married U.S.A. 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PARKING LOT MANAGER 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **GOODMAN** FANNY FRIEDBERG KAUF 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3122 LUGINE AVENUE - BALTIMORE, MD 21207 ANNA GOODMAN / WIFE 20b. Place of Disposition (Name o 20a. Method of Disposition BETH TFILOH CONG. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/26/2007 WOODLAWN, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): clisecis /Medical Examiner Acutic valve disease Sequentially list conditions, if any, leading to in modal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown UVInam Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 3□ DOA 2 ER/Outpatient 1 Inpatient Medical Certification: To this 27. Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

within 24

DR. HARRY KAPLAN 31. Date filed (Month, Day, Year) Registra

29b. Signature and title of dertifier



MAR 2 7 2007

30. Name and address of persod who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

D4037

BALTIMUNE, MO 21208

29d. Date signed (Month, Day, Year)

3/24/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death as acon **Physician** 11:55 P.M /Medical istitution, give M City, Town, or Location of Death County of Death Examiner Prince Frederick Nursing If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Days Hours Director 218-54-7799 93 **DEC 29** 1913 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or items ???? 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Calvert **Owings** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2711 Dogwood Lane 20736 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White ģ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbur ပ A. Johnson Clara Mae Frank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2711 Dogwood Lane, Owings, Maryland John Gay - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 3/26/2007 Baltimore, MD 21. Signature of Funeral Service Licensee Cremation Society of Maryland, 299 Frederick Road, Baltimore, Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed 166 and Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1□ Yes 2□ No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death. I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 Yes 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical

Division or Vital Records, P.O. Box 68760, To the Hospital within 24 hours a To the Funeral C

ID

DHMH 17 Rev 1/2001

State

(Check only one)

29b. Signature and title of certifier

pleted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Rd. Suite 305 Prince Frederick MD. 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09580 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:15A SAMES GINGLES 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RIEN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**X** M 2□ F 212-28-809 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r 28a-f shov notified at HAR FORG 1 ☐ Yes 2 ☐ No Director ALLS TON 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or U.S.A 1403 21047 Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Folces.

1 XYes 2 No
If Yes, Give
Year or Dates: 1951-55 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☑ Divorced Black Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other than traumatic event, the M 1214 EThlehe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOAN SERTRICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Department of Health Important: if Item 27 any Injury or other tronce. -LAUREL, aINGLES Md. 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 30/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 2700 EdMONDSON 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VASCULAR dementia Physician END STAGE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to limited at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy fo in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death P.0. ate has been signed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by Cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CLABETES 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【 V No 24a. Was an autopsy performed? certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, To Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number D35102 26, 2007 usuul MAVUH Name and address of person who completed cause of death (Item 23a) (Type, Print) 5901 north CHANLES STrick Baltimore Marylang Donm.n. lti la N 31. Date filed (Month Day, Year) gistrar's Signature State MAR 2 7 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:24 am M Mary D. Gardner March 21, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 6. Sex Social Security Number **Funeral** Days Hours Min. 1□ M 2 JF 90 578.22.3347 December 16, 1916 Virginia Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c, City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Mt. Airy Maryland Howard Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21771 925 E. Watersville Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Was Decedent Ever in U.S. Armed Forces,? Black, White, etc. ☐ Yes 2 Yes, Give 1 Never Married 2 Married 2 No "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify If Yes, Give Year or Dates: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) at home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annette (unknown) John Davis ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 925 E. Watersville Road Mount Airy, Maryland 21771 Daughter Ms. Bobbie Gibbon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 'Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/24/07 Baltimore, MD **Bayview Crematory** 5 Other (Specify) 4 Donation 22. Name and Address of Facility Signature of Funeral Service Lic Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 nt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final lse or condition ting in death) difficule colotis clostridium days **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9☐Unknown 9 Unknows 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Tyes nis certificate has been si director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed' 2 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA after death.

Director: After this in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) Natural 2 Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D59138 icra J. Mistry MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive Rockville, MB 20350 9901 T. Mistry 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 ASIA. S 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09582 Certificate of Death 2. Date of Death **Physician** Month 5:20 am Mar 07 /Medical ity Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospita Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Se Birthplace (State or Foreign
 Country) **Funeral** last birthday -16-708 Director Usual Residence of Deceder Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ural", or items 23a or 28a-f show | Examiner must be notified at 10d. Inside City Limits 1 Kes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items any Injury or other traumatic event, the Medical Examiner mu 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses M01343 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** neumonia 7-days /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician the burial Physician/Medical as IF FFMALE asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy to in the past 12 months? Month Year 5 ☐ Other (specify) 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 🗌 Yes page 2 should 3 Probably 4 □Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1□ Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Mar, 27,07 e, Bultimore, MD, 21299 30 Registrar's Signature 31. Date filed (Month, Day, State Registrar 2007

State of Maryland / Department of Health and Mental Hygiene 1 1 7

	1	For State of Maryla	nd / Depa	rtment of He tificate of D	ealth and Moeath		giene () Reg. No.	07	09583
Physiciar		I. Decedent's Name (First, Middle, Last) Katrina Helmick		1-1		2. Date of Dea Month	Day	Year	3. Time of Death
/Medica		ia. Facility Name (If not institution, give street and number)		4b. City, Town, or	ocation of Death	3/23	/2007 4c. Coun	ty of Death	12:15pm
Examine		502 East Clement Street			ore MD			N/A	
Funeral Director		219-90-1916 ^{1□M 2} √∃₹ 29	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date 3/10/	y, Year)	9. Birthp Coun	lace (State or Foreign htry) MD
riand ow	- 1-		City, Town or Lo		G.1.1			1	0d. Inside City Limits
e Man	5	MD N/A		Baltimore	e City				1 X Yes 2 □ No
with the a or 28	5	10e. Street and Number 502 E. Clement Street		10f. Zip Code	21230		10g. Citizen o United		
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23s or 28s-f show event, the Marical Extrainer trust be notified at	Dy ruileral	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1	i	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. R B	ace - Americ lack, White, lify: V	
72 hor	ם ב	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupa kind of work done d	urina most of work	ting	16b. Kind of	Business/Ind	dustry
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d be filed ental Hygid ked other c event, II	0	17. Father's Name (First, Middle, Last) Walter L. Helmick			18. Mother's Nam Susan E			ame)	
and 2 should lealth and Men n 27 is markener traumatic	0	19a. Informant's Name/Relationship (Type, Print) Susan E. Barcroft / Mother	19b. Mailir 502	g Address (Street a East Cler	nd Number or Rui ment Stre	et, Bal	er, City or Tow Ltimore	m, State, Zip MD 2	1230
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than instumony or other traumetic event. Its Madical once.		20a. Welliod of Disposition		sition (Name of natory or other place Crematory) l	Date 7/2007	20c. Location		
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	C Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury. A building, etc. (Sp.	t home, farm, str		(? Yes 2 □ No		Street and Nu wn, State)	m <i>ber</i> or Run	al Route Number,
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59		30-Name and address of person who completed cause of death	Item 23a) (Type,	Print) 1	11000	C TZ	Bal	1 to	N-Uni
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DHMH 17 Rev 1/2001

07-02254

Physician/ Medical Examiner Sharon Rose Henke1 4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center Funeral 5. Social Security Number Charon Rose Henke1 4b. City, Town, or Location of Death Bel Air If Under 1 Year If Under 24Hrs. Anothe Day Year Month Day Year Month Day March 24, 2007 4c. County of Death Harford Foreign	Sharon Henkel		S1 1- For State	tate of Maryl		partment of <i>ertificate of</i>		and	Menta	al Hyg			200	7	09581
March 24, 2007 Control of Death Control of De	Physicia		Registrar 1. Decedent's Name (First, Midd	lle,Last)		- Continuate of	Dodan			2	Date of Dea			3 Time	of Death
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138-66-0300 Mary Land Court Too Co			5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)							Fore	eign	
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Christopher Henkel (Hisband) 123 Author of Comments of Security 20 Author of Comments of Security 21 Stypling of Function 5 Other Security 22 Supplies of Function 5 Other Security 23 Name and address of Facility 24 Dogston Nine of comments of Security 25 Name and an address of Facility 26 Name and an address of Facility 27 Name and an address of Facility 28 Name and an address of Facility 29 Name and an address of Facility 29 Name and address of Facility 20 Name and an address of Facility 20 Name and address of Facility 20 Name and address of Facility 21 Name and an address of Facility 22 Name and an address of Facility 23 Name and address of Facility 24 Name and address of Facility 25 Name and address of Facility 26 Name and address of Facility 27 Name and address of Facility 28 Name and address of Facility 29 Name and address of Facility 20 Name and address of Facility 20 Name and address of Facility 20 Name and address of Facility 20 Name and address of Facility 20 Name and address of Facility 20 Name and address of Facility 20 Name and address of Facility 20 Name and address of Facility 20 Name and address of Facility 21 Name and address of Facility 22 Facil death Do not enter the mode of dyng, such as cordeacy areast, shock, of heart and name a	212 buld b i Meni marli ic eve			ship (Type, Print)		19b. Mailing	Address	(Street	and Numb	er or Ru	ral Route Nu	mber, C	ity or Town, Sta	te, Zip Cod	de)
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29b. Signature and title of certifier O.C.M.E. March 25, 2007 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 2007 32. Registrar's Signature	760 cate b	Me		23c. If yes	, outcome of p	regnancy		_	-			23		•	Vaer
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29b. Signature and title of certifier O.C.M.E. March 25, 2007 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 2007 32. Registrar's Signature	or the lacked		Part II. Other significant condi	tions contributing	to death but no	ot resulting in the u	inderlying c	ause giv	ven in Part	11.	23e. Did				
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O.C.M.E. March 25, 2007 30. Name and address of person who completed cause of death (item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 2007 32. Registrar's Signature	To T To I	Med			stated		29c.	License	number			29d.	Date signed (A	Aonth, Day	, Year)
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 2007 32. Registrar's Signature	1	==	101/1- 50	mall	1121			O.C.N	1.E.			Ma	rch 25, 200	7	
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 2007 32. Registrar's Signature	4	}	30. Name and address of perso	n who completed ca	use of death (I	tem 23a)									
	U						enn Stre	et, Ba	ltimore,	MD 2	1201				
		ate	31. Date filed (Month, Day Year	2007	Registrar's Sig	pature	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 34 Physician Peggy Harne-Lantz 6:02 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FRANKLIN ROSEDALE SQUARE HOSPITAL 8. Date of Birth (Month, Day, Year) April 9, 1940 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 T F Davs Hours Mary Land 218-36-0070 66 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Extender must be notified at 1 ☐ Yes 2 No Maryland Directo Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 962 Lance Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc HARNE-LAN 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 📉 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 years Mortgage Credit Investigator Mortgage Company Important: If Item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Leoffler John Morosko ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Dolly 962 Lance Avenue, Essex, Maryland Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 29 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) St. Stanislaus Cem. Baltimore, Maryland 2007 21. Stature of Funeral Service Licenses 22. Name and Address of Facility Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading L. immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed bunial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a Was an was a... autopsy performed? Yes 2 No page 2 To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 1 Inpatient 2 K ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) after death. I Director: After the in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 💹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

9000 Franklin Square brivE Baltimore maryland

30. Name and address of person who completed course of death (Item 23a) (Type, Print)

32. Registrar's Signature

Pipkin

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the f

> State Registrar

(Check only

29b. Signature and title of certifie

31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

MD

2835

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAKEBUIT,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 13 26 PM MARCH HOFFEPIEGEL 25 2007 minnie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHOCK TRANMA CENTA RALTIMORE ADAMS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Country 10/22/1929 MD 217-26-1427 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No MD BALTIMORE N/A Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5604 BLAND AVENUE 21215 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. be filed within 72 hours after 1 ∐ Yes 2 **X** No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No WHITE 3altimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CLERK MARYLAND STATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd Mental F **JACOB** SOKOLSKY SARAH ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health em 27 i <u>JILL WELSH / DAUGHTER</u> <u> 5604 BLAND AVENUE - BALTIMORE, MD 21215</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) ANSHE NEISEN 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/27/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility re of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. 23a. Pah / Enjer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** THORACOABDOMINAL ANEURYSM REAGIR 3 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ANEURYSN IHORACOABDOMINAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical 35 IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 4□Pregnant at time of death ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown CORONARU ARTERY 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an HYPERTENSION autopsy certificate ha 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖟 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 17385

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RO

32 Registrar's Signature

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TRAUNA CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** Winston Harris 0120A march 2007 26 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Care Bayview Baltimore Johns HOPKINS Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months 1**X**M 2 F Yrs. 219-12-8089 85 AUG 21 NC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or itema 23a or 28a-f ehow It e Medical Examiner must be notified at 1 Yes 2X No Director MD Baltimore Gwynn Oak 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 USA 2904 Fendall Road Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: WWII 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by **Black** 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Trucking other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked o Mitchell 1 Mollie Alfonzo ပ Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2904 Fendall Road, Gwynn Oak, MD Eva Harris - wife permit. Pages 1 and Department of Health important: if item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 3/26/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Veensee H. Williams Name and Address of Eacility. Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial **Physician** intarc /Medical Due to (or as a consequence of). Examiner iabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ysician and e burial-transit The law requires that the death certificate be executed Brain that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the L as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No for u 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 autopsy 2 No certificate Yes or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4- Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA ٩ 2 No this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Injury 1 Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a To the Funeral I To the Hospitai 29a. Certifier 1 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

P.O.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certified



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

035763

29d. Date signed (Month, Day, Year)

Baltimore, Md 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** March 7005 M harlotte Holzer /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gardens Caknovil Renaissance 6. Sex (In vrs. last birthday) **Funeral** Months Hours Mary land 1 □ M 2 💢 F 215-07-8009 94 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Catonsville Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 701 Maiden Choice Lane **USA** Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ite 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 ☐ Xio 3altimore, Maryland 21215-0036 Specify. 2 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary McMahon Lee Carroll Melvin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is 1 508 Fairmont Avenue Towson, Maryland 21286 John Carroll Holzer, Son injury or other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition buranevovarilev Memorial Gardens 1 XBunial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 03/27/07 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor ²² Name and Address of Facility Home, P.A. MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Yeous **Physician** Atherosclaratic coronary artery /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Dementio page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 2 No 1 TYes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wla 31. Date Ned (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

M Carpenter

Maiden Choice In Odbnsville

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 30989

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Heller Frances С. MARCH 19. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Baltimore Towson Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept. 13, 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 3. 1920 Funeral Days Hours Min. 1 □ M 2 X F North Carolina 86 238-16-4643 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at show 1 ☐ Yes 2 X No Md. Baltimore Glen Arm **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a or USA 21057 4110 Halifax Court death v 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Nurse +4 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cheek Monnie Fryin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4110 Halifax Ct. Glen Arm, Md. 21057 Mr. Randall Heller/ Son Item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Hilltop Service Co. 3-26-07 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ADULT RESPIRATORY DISTRESS SYNDROME if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA 1 Tes 2 No 3 Probably 4 Unknown Completed RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy page 2**2** No CONGESTIVE HEART FAILURE 2 No 1∐ Yes 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

reral Director: A

within 24 hours a

5 Pending investigation 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D37254

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POH LIM, 7601 OSLER DRIVE TOWSON, MARYLAND MAD BOON

31. Date filed (Month, Day, Year)

32. Registrar's Signature MAR 2

Medical

State

Registrar

			State of Mary State State Registrar 1. Decedent's Name (First, Middle, Last)	_	rtment of He			g. No.	0 9 5 9 1
	Physici		Josephine Magdalene		Hertz		Month March 2	Day Year	12:20 A ^M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	120020
		2	Genesis Elder Care Hammond's		Brooklyn			Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 1 M 2 M F 7. Age (In 1 M 2 M F 7. Age (In 2 M F	n yrs. last birthday). 95 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 7,	Year) 9. Birth Co.	place (State or Foreign intry) PA
	Maryland f show ed at	or	Tod. Otato	c. City, Town or Lo					10d. Inside City Limits 1 □Yes 2 🗓 No
	the N 28a-	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	intry?
	3a or	I Di	327 Ferndale Road		21061		U	.S.A.	
020	d within 72 hours after death with the Maryland jiene. I than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ⚠ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 □ Yes 2ሺ No		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
0500-617	filed within 72 ho Hygiene. other than "natur ent, the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of workin	ng 1	6b. Kind of Business/II Own Home	ndustry
7	Hygien her th	S	17. Father's Name (First, Middle, Last)	пошеш		18. Mother's Name	(First, Middle, M		
Maryland		To Be	Alois Rothen			Teresa F		,	
Ar yı	shoul nd Me mark	ř	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a			City or Town, State, Z	ip Code)
Ĭ,	and 2 saith a 27 is		Mr. Kenneth L. Hertz /Son					, MD 21061	
Dallillore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic es once.		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		sition (Name of matory or other place r's Cemet	1	1 31,	Roc. Location - City or T Butler, PA	own, State
סשור	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee					Funeral Hor	
ą.	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	death. Do not ent					Approximate Interval Between Onset and Death
1	/Medical Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Stage	Dew	ent's			
,00,00	ficate be executed g physician and is the burial-transit	edical Examiner	that initiated events resulting in death) Last C	onsequence of):					
.O. BOX 0	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
_	w requires that to be seen signed by should be detail	by	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to s 2 □ No 3 □ Pro	
records,		Completed				<u>. </u>	24a. Was ar autops perform 1 Yes 2	prior to c	topsy findings available ompletion of cause of 2 ☐ No
VII	iclan: Th certificate ector, pag	Be (25. Was case referred to medical examiner?		Otho	26. Place of Death	(Check only one)	
5	Phys r this ral dir	ို	1 Yes 2 PNo Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	f 28c. Injury Work	at 2		nce 6 □Other (Spec w injury occurred	ify)
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	Accident 3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (s			∕es 2□No	28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
	Hospital	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of manner stated and manner stated	amination and/or in	h occurred at the tin	ne, date and place, a pinion, death occurr	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	ro the vithin го the	Me	29b. Signature and the of certifier		29c. License	number	29	9d. Date signed (Month	n, Day, Year)
	0			MD	D	53462		3/26/07	
	5		30. Name and address of person who completed cause of death			_	I Glev		2106 (MD
H	Sta Registi		31. Date filed (Morkh, Day, Year) 32. Registrar's	Signature					

	1	For Amend Item 2		Ce	rtificate of l	Jeath		No.	0 T:(5
		1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Day Year	3. Time of Death
sicia			Daniel Mi	chael Hips	ey		March	18, 2007	6:53 a. M
ledic amin		4a. Fecility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	th
		Howar	d County Gener	ral Hospital		Col	umbia		loward
erai			Sex, 7. Ag	e (In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	thplace (State or Foreign ountry)
tor		216-16-0687	1 M 2 F	81 Yrs.	WOTHING Days		October 31,		Maryland
		Usual Residence of Decedent							10d. Inside City Limits
1		10a. State 10b. County		10c. City, Town or L	ocation				1 Tyes 2 No
	ō	Maryland	Howard		F	Ilicott City			1 1 105 2 2010
	Director	10e. Street and Number	1011414		10f. Zip Code	,	10g.	Citizen of What Co	ountry?
1	<u> </u>	2977 Normandy Dr.				21043		U.	.S.A.
	by Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame Black, Whit	
	5	1 Never Married 2 Married	Amred Forces		1	n, Mexican, Puerto	rican, etc.)		le, etc.
7	5	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1943	1 Yes 2 No	Specify:		Specify:	White
		15. Decedent's	Education	16a, Dece	dent's Usual Occup			. Kind of Business	/Industry
	Completed	(Specify only highest of	grade completed)	lite.	e kind of work done o DO NOT use retired	during most of work 1)	ng	Incura	ance Sales
	티	Elementary/Secondary (0-12)	College (1-4or	5+)	1	Attorney		moure	ande dates
		17. Father's Name (First, Middle, La	5+				(First, Middle, Mai	den Sumame)	
	Be						Canhia	Zimmerman	
	၉		Henry Hipsley	105 140	inn Address (Street	and Number of Pur	al Route Number, C		
		19a. Informant's Name/Relationship	(Type, Print)						
		Ms. Edith Hipsle	y				City, Marylan	d 21043 c. Location - City or	Town State
		20a. Method of Disposition 1 DBurial 2 DCremation 3	Demoval from State	20b. Place of Disp cemetery, cre	osition (Name or ematory or other plac		20	c. Location - Oily or	TOWN, Dialo
	1	4 Donation 5 Other (Spe			Veterans Ce	metery 03	/26/2007	Garrison Fo	orest, Maryland
		21. Signature of Funeral Service Lic	censee	-C	andson Fores	ss of Facility			
		Mallod IXA	of Duch + N				e, P.A.		
	\vdash	23a Part 1 Enter the disease or Co	omplications that cause	ed the death. Do not en	3871 (nter the mode of dyli	Old Columbia ng, such as cardiac	Pike Ellicott (or respiratory arrest	ity, MD 2104	Approximate Interval Between
		23a. Part1. Enter the disease, or co shock, or heart faiture. List or	nly one cause on each	line.	Λ.	11.0	avetu		Onset and Death
		Immediate Cause (Final disease or condition resulting in death)	-a. Ha	se My	Xavara	N 1N4	avon		
		1830tting in Godiny	Due to (or a	s a consequence of):					
		Sequentially list conditions,	b						
	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence of):					
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		resulting in death) Last	Due to (or a	s a consequence of):					Î
	Ca		d						
	ed								1
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pregnanc	v		23d. Date of de	
	Cia	in the past 12 months?	4 ☐ Pregnant	at time of death 5	Other (specify)	<i>y</i>		Month	Day Year
10	32	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
		Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
	þ						1 🗆 Yes	2 No 3 □ F	Probably 4 Unknown
	Completed						24a. Was an	24h Were a	autopsy findings available
	ğ						autopsy	prior to	completion of cause of
-	ĕ							No 1□Ye	s 20 No
	0	25. Was case referred to medical					th (Check only one)		
	To B	examiner?	Hospital: 1 ☐ Inpa	tient 2 ER/Outpati	ent 3 DOA	her: 4 🗆 Nursing H	ome Statesiden	ce 6 □Other (Sp	pecify)
		27. Manner of Death	28a. Date of In (Month, D	jury 28b. Time		ry at	28d. Describe how	injury occurred	
	Certification:	1 Natural 5 Pending 2 Accident investiga	The second secon	Day Year) Injury		Yes 2 □ No			
	ica	3 Suicide 6 Could no	200. 1 laco oi i	njury - At home, farm,	street, factory, office	2			Rural Route Number,
	Ē	4 Homicide	building,	etc."(Specify)			City or Town,	3(8(6)	
	18	an Continue of Continue	Obveiging: To the ba	st of my knowledge, de	ath occurred at the t	ime date and place	and due to the cau	se(s) and manner	as stated.
			Physician: 10 the basis	of examination and/or	investigation, in my	opinion, death occu	rred at the time, dat	e and place, and di	ue to the cause(s)
	icai ((Check only 2 Medical E	Kanimier. On the Dasis						
	edicai	(Check only 2 Medical E	and manner	stated.		se number	290	d. Date signed (Moi	nth, Day, Year)
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	edicai	(Check only 2 Medical E	and manner		29c. Licen	se number 0517	10 Ban	d. Date signed (Moi 3/2-0/0 As MC	nth, Day, Year) 7 3 21224
	Medical	(Check only 2 Medical E	and manner Ano completed cause o	f death (Item 23a) (Type	29c. Licen	se number OS17	10 Ban	d. Date signed (Moi	nth, Day, Year) 7 3 7127 Y
	edicai	(Check only 2 Medical E one) 29b. Signature and title of certifier 30. Name and address of person w	and manner Ano completed cause o	f death (Item 23a) (Typ	29c. Licen	se number OS 17	10 Ban	d. Date signed (Moi 3/20/0 Ab MN	nth, Day, Year) 7 5 71278

			For State Registrar	State of Marylar		artmer <i>rtificat</i>			Mental Hy	giene Reg. No	UUI	09593
	Physici		1. Decedent's Name (First, Middle, Las	MALLIE ELIZ	ABETH	HUNTE	CR		2. Date of De Month March	Day		3. Time of Death 7:50 A M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)	-	4b. City,		Location of Dea	ith		County of Death	
ı	Funeral Director		231-09-4947	744 000 0	. last birthday) 37 Yrs.	If Unde Months	1 Year Days	If Under 24 Hr Hours Mir			9. Birtl Co 19 Sout	nplace (State or Foreign untry) ch Carolina
	Aaryland Febow	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Art		ity, Town or Le	ocation	Ba	ltimore				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the hard or 28a-	Director	10e. Street and Number 302 01d R	iverside Road		10f. Zij	Code	212	25		izen of What Co USA	untry?
36	2 should be filed within 72 hours after death with the Maryland and Menkel Hygiene, and Menkel Hygiene is marked other than "natural", or iteme 23a or 28a-f ehow asmatic event, tra Medical Examinational be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 🖫 Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	J.S. 13.	Was Dece If Yes, spe		spanic Origin? (n, Mexican, Pue Specity:	Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	vithin 72 hourne. Ine. "natural	Completed t	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		kind of wo DO NOT u	ork done d ise retired	during most of w			ind of Business/	
land 2	be filed tal Hygi d other event, I	To Be Co	8 17. Father's Name (First, Middle, Last) Willia	m Bryant	Elec	ctric	COL		ame (First, Middle ie E. Ma			
e, Mary	permit. Pages 1 end 2 should Department of Health and Men Important: if Item 27 Is marke any injury or other traumatic. once.		19a. Informant's Name/Relationship (7 Elizabeth A. Still 20a. Method of Disposition	well (Daughte		29 Ca	rter		Rural Route Numb ykesvill Date	e, M		4
altimore,	t. Pages rtment of h rtant: if tte njury or of		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 1 Signature of Fineral Service Licen.	Removal from State	cemetery, cre edar Hi	ill Ci	metei	ry 3/2	6/07	Balt	imore,	Maryland
Ba	Depa Impo Impo any id		1/2		1	237 E	. Pat	apsco A		to.,	Md. 21	225-1856 Approximate
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or composition shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	ntra	ter the mo	de or dylin	g, such as cardi	ac or respiratory a	irrest,		Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse c. Due to (or as a conse d								
.O. Box 6	that the death certifical led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	⊒Ectopic ρ ⊒ Other (s					23d. Date of dei Month	ivery Day Year
α,	quires that in signed by ald be deta	þ	Part II. Other significant conditions or	ontributing to death but not re	sulting in the u	underlying	cause give	en in Part I.			/	the cause of death?
il Records,	The law requires that the sete hes been signed by the page 2 should be detache	Completed							24a. Wa: auto perf 1 ☐ Yes	s an opsy ormed? 2 No	prior to death?	utopsy findings available comptetion of cause of
Vital	ysician: The I is certificate he director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 [⊒ ER /Outpatie	nt 3□ D	OA Oth	or .	eath (Check only Home 5 ☐ Res		6 ☐Other (Spe	cify)
Division of	Jing Ph I. After th funeral		27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of M	28c. Injun Worl	y at k? Yes 2 □No	28d. Describe	how intu	ry occurred	
Divis		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, larm, st	reet, lacto	ry, office		28l. Location City or To			ural Route Number,
	To the Hospital or within 24 hours afte to the Funeral Dirr completely filled in I	dicai		valcium: To the best of my kn ilner: On the basis of examin and manner stated.	ation and/or in	rvestigatio	n. in my o	pinion, death oc	curred at the time	date an	d place, and due	to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	- 1110		29	Oc. Licens	e number	>	29d. Da	te signed (Mont	h, Day, Year)
	4		30. Name and address of person who o	completed cause of death (Ite	om 23a) (Type	, Print)	307	West	nnch.	111	071	157
İ	Sta Registr		31. Date liled (Month, Day, Year) MAR 2 7 2	and manner stated. Completed cause of death (Ite 295 Stone) 32. Registrar's Sign	nature	barta.	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 22:46 M 2007 Teresa Anna Jenks MARCH 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2X F 197-16-9153 81 Sep. 11. 1925 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🏖 No Director Harford Maryland Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1101 MacBeth Court 21015 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XNo Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fii lealth and Mental H Be James F. McCulley Anna M. Gormley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1101 MacBeth Court, Bel Air, Maryland 21015 Patricia Cook/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H
Important: If Ite
any Injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Hillside Cemetery 3-28-07 4 □ Donation 5 □ Other (Specify) Roslyn, Pennsylvania 22. Name and Address of Facility
McComas Funeral Home, P. A. 21. So valure of Funeral Gentice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt-failure. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Immediate Cause (Final disease or condition resulting in death) Systemic Inflammatry Response **Physician** 10 days /Medical Du- lo (or as a consequence of Examiner Lower Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine be executed Acute Subcon burial-trar Due to (or as a consequence of) attending physician for use as the burial 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔊 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe Emphysema rmed / 2 X No this certificate 25. Was case referred t dedical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **7**40 1 ☐ Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. I Director: A 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 😥 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) 70056607 March 23rd 2007

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANGEZO

31. Date filed (Month, Day, Year)

#205

602 S. ATWOOD RD BEL AJR, MD21014

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09595 Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year MARCH 13:35 Physician 23 2007 Anna Mae Jenkins /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Baltimore
If Under 24 Hrs. University Specialty Hospital

5. Sociel Security Number | 6. Sex | 7. Age (In yrs. lest birthdey) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min. 1 □ M 2√2 F Yrs. Director 204-26-9632 71 Maryland Apr. 6. 1935 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show item 27 te marked other than "naturel", or items 23a or 28a-f sho other treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 1105 Montreal Drive 21001 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Pages 1 end 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑No Specify Specify. Ś 3 Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be end Mental Edward Paca Moore Gordon Anna Pearl Carlisle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen L. Kuhn/Daughter Depertment of Health important: if Item 27 714 Plater St., Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mountain Christian Cem. 3-28-07 Joppa, Maryland 22. Name and Address of Facility
McComas Funeral Home, P. A. 21. Signature of Funeral 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter(the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical arrythemias Correllac 10 MINURS Examiner Due to (or as a consequence of) Examiner heam - diseuse 5 425 therus clarotic Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Cerebrovo vascular acolomic 10 dans edical Due to (or as a consequence of): Carcinoma maxilla a Urs Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown anemia ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate hes b director, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 - ER/Outpatient 3 - DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Director: After th 28c. Injury at Work? 27. Manner of Deeth 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by 4 ☐ Homicide 0 To the Hospitai 1 icritifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. edicai 29a. Certifier 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/13/07 030494 KOESAIM 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) GOI SOUTH charles street Baltimore MDV1230 WSH X DESAIMO

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

JENEINS

32. Registrer's Signature

7 2007

Tracey Allen Keefer

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			ate o	f Death							
Physiciai ledical Examin	1/						- 1	Month	Day 2, 2007		3. Time of Death 1745 hrs
		4a. Facility Name (if not institution, give street and number) Franklin Square Hospital		4b. City, Town Parkville	, or Lo	ocation of	Death			•	
Funeral Director		5. Social Security Number 220-96-7343 6 Sex 1 Age (In yrs. last birt 4 0		Months		If Under Hours	24Hrs. Min.				
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ne Maryla or 28a-f	Jirect 1		•			234					intry?
after death with the death of the state of t	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year		Yes, specify Cu	ıban, I	Mexican, F			l w	hite, etc. W h	ican Indian, Black, nite
5-0036 iled within 72 hours: Hygiene A other than "natur: the Medical Exami		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bo	during r	most of working	ilife. E	обиот и 1 WO	se retired rker	d) -	John Ho	n Hop Spit	okins
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MD 21 d 2 should b Ith and Mer n 27 is mar	ှိ	Barbara Lee Keefer-mother 1	000	5 Near	br	ook	Lar	ıe-Pa	rkvill	e,Ma	aryland
- s 4 = 4		1 X Burial 2 Cremation 3 Removal from State BeTG.	Ayır ard	Memoi ens	ria	1			Bel	Air	,Maryland
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Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic intoxication					10100011	oopii atory a			Between Onset and
	aminer	Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated									
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lirecto	m۵	examiner? Hospital: 1 Innatient 2 ERIC	utpatie			241			Residence	6 🗸 Oth	er: Scene
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been so led in by the funeral director, page 2 should be a	۲	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. 1 Natural 5 Pending Fnd. 3/23/2007 Fne.		1					e how injury oc	curred	
Division of Atta	rtifica	3 Suicide 6 X Could not be determined (Specify) Find cincile	arm, str	eet, factory, of		_	i. 2	28f. Location or Town	(Street and Nu , State)	mber or R	tural Route Number, City
the Hospit hin 24 hour the Funera		29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, de one) Medical Examiner: On the basis of examination and/or	ath occ	urred at the tim	ne, dat	te and pla	ce, and c	lue to the ca	ause(s) and mar	nner as sta	ated.
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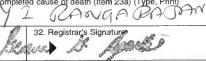
DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year) 2007

POVI

ASWAM



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

054288

MORTHWEST HOSPITOL CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Gerard W. Koth \mathbf{P}^{M} March 20, 2007 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth OCT. 1, Year) 42 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 220-40-9730 1**X** M 2 □ F Mary and 64 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f sh notified Md. Baltimore Ruxton 1 ☐ Yes 2 X No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 3 and injury or other traumatic event, the Medical Examiner must be no gine. 25 Ruxview Ct. #101 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County School System Elementary/Secondary (0-12) College (1-4or 5+) + Д Psychologist Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Ε. Howarth Koth Theresa 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 Willoughby Rd. Parkville, Md. 21234 Ms. Chrissy Koth/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 3-27-07 Dulaney Valley Mem. Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility Luneral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service I censes 23a. Part1. Enter the disease, or con shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) or s a consequence of): **Physician** 10 hours /Medical Examiner Metaboli 12 hours Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed End End Stage U

Due to (or as a consequence of): Z. Weeks the attending physician and hed for use as the burial-tran P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? $\int \partial y d \int \partial y d = \int \partial y d d$ Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has performed 2 100 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending after death. 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

CRMC

lauson MD

Street.

N. Charles

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001

HAYSO

(Month, Day, Year)
MAR 2 7 2007

31. Date filed (Month, Day,

		1 - State Amend #5 Pe		4705/	0/ Jh	tificat	e of L	Death	1	2. Date of Dea		UU/		3. Time o	of Death
Physici	an	Decedent's Name (First, Middle, La Karl Keene	Sr)							Month 03	2 ^{Day}	200	ź	9:4	
/Medio Examin		4a. Facility Name (If not institution, giv Joseph Richey Nursin		or)		4b. City		Location o			4c. (County of De	eath		
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aud **		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10	d. Inside C	Dity Limits
Many Ind	tor	MD				Ba	1timo:	e						1 X Yes	s 2 No
3s or 28s	Il Director	10e. Street and Number 518 N. Pulaski Stree	et			10f. Zi	p Code	212	223		10g. Citiz	en of What USA		ry?	
De lide within 72 nouts after death with the maryland ital Hygiene. Ital Hygiene. Ital Hygiene. avant, tra Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Tyes 2 If Yes, Give Year or Dates	s? Mno	- 1	Was Dece f Yes, spe 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		4. Race - Ar Black, W Specarri	hite, e	tc.	can
natur dical	eted	15. Decedent's E (Specify only highest gra			16a. Deced	kind of w	ork done d	luring most	of worki	ing	16b. Kin	d of Busine	ss/Indu	ustry	-
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f Heelth and Mental flam 27 is marked other traumatic av	Ĕ	19a. Informant's Name/Relationship (•			-				al Route Number					
Heell		20a. Method of Disposition		000	ace of Dispo	sition (Na	me of			Date	<u> </u>	ation - City			
nt: If		1 A Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		te e	g Memor			1	3/30/2	2007	Randa:	11stown	, N	aryla:	nd
Depentra Importa any inju		21. Signature of Funeral Service Lice	nsee (. Name a	nd Addres	s of Facility		Wylie Fu					
4 4 4		Zsa. Part1 Enter the disease, or com			Da					et; Balt		, Maryl		2121 [°] Approxima	
nysician Medical xaminer	į	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. ESO P. Due to (or a	HAGE as a conseque		An	KER							Interval Be Onset and	
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pe eq	۵	Part II. Other significant conditions	contributing to death	n but not resul	ting in the u	ndertying	cause give	en in Part I.			obacco us res 2 🗆	se contribute		cause of	
ste has been signed by the attending ph page 2 should be detached for use as th	Completed									24a. Was autop perfo 1 🗆 Yes		24b. Were prior death	to com	sy findings pletion of	s availab cause of
certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				1/	
S D	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ∐ Inpa 28a. Date of Ir	njury :	R/Outpatier 28b. Time of		OA Injun Won	4 🗆 Nu	т.	me 5 Resident			pecify)	HOS	PICE
within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	e 200 Place of	Day Year)	Injury	М	10	(? Yes 2 □ I		28f. Location (Rural	Route Nui	mber,
4 hours efter Funaral Dira		4 Homicide	building,	etc. (Specify)		h occurred	s at the time	no date an	d place	City or Tov			as sta	ited	
24 hc P Fun etely	Medical		miner: On the basis and manner	of examination											(s)
within To the comple	Me	29b. Signature and title of certifier					c. License					signed (Mo			
Z ,- Q		Maril	-MD			1	D002	263.	27	-	3-2	4-20	00	2	
3		30. Name and address of person who	completed cause o	of death (Item	23a) (Type,	Print)	QE.	Col	OM	BIA, 1	MD	210	340		
Str	ate	31. Date filed (Month, Day, Year) MAR 2. 7 200		strar's Signati	ILO N	A	1		الحبوب	-111					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan		rtificate of		-	Reg. No. 2	107	09600
	Physic	an	1. Decedent's Name (First, Middle, Las ANNAC, KULF					2. Date of De Month	Day	Year	3. Time of Death
N.	/Medi Examir		4a. Facility Name (If not institution, give		ENTER	4b. City, Town, o	or Location of Death	MARC	-	2007 ty of Death	1402 PM
		IGI	JOHNS HOPKINS	_		BALTI				ty or Bodin	
5	Funeral Director		212 07 3772		ast birthday) 39 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da		Coui	place (State or Foreign ntry) nsylvania
	yland Iow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	leath with the Marylan ns 23a or 28a-f show must be notifled at	Director	Maryland Baltimo	ore Gra	acelan	d Park					1 □Yes 2 □ No X
	with th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
	ns 23 must	Funeral	541 South Fortys	seventh Street 12. Was Decedent Ever in U.	S 13 1	Vas Decedent of I		posify Voc or No	U.S.,	A. ace - Americ	ean Indian
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. The first state of the than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fun	1 Never Married 2 Married 3 √Widowed 4 Divorced	Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		if Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	Rican, etc.)	Speci	ack, White,	etc.
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	e filed al Hyg other vent, 1	Be C	17. Father's Name (First, Middle, Last)			JOK	18. Mother's Name	e (First, Middle,	Faidle		earood
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	1 and Health lem 2		Joseph D. Prematta 20a. Method of Disposition			b West St sition (Name of	nady Drive	Data	zille, 1		
Baltimore,	0 0 		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crer	natory or other pla	Marc	ch 27		,	
alti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service by	Dayv		cematory . Name and Addre	ess of Facility		Baltimo:		7.50
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	ss that jned b	by P	Part II. Other significant conditions co	ontributing to death but not resul	Iting in the ur	iderlying cause giv	en in Part I.	23e. Did to	obacco use con	tribute to th	e cause of death?
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Ξ.	Physiclan: r this certificatal director, I	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐Inpatient 2 ☐ E	R/Qutnatien	3 DOA Oth	26. Place of Death				
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Division	Attending It death. ector: After by the fune	catio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 ☐ Yes 2 ☐ No							
) X	- 2	Certification:	4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					l Route Number,		
_	To the Hospital of within 24 hours aff To the Funeral D completely filled in	Medical Ce	29a. Certifier (Check only one)	vsician: To the best of my know iner: On the basis of examinati and manner stated.	/ledge, death on and/or inv	occurred at the tile restigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as st	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and tyle of certifier			29c. Licens	e number		29d. Date signe	ed (Month, I	Day, Year)
						RES-	000		MARCH	22,	2007
	3		30. Name and address of pareon who c	OB 4940	GASTE	ORN AV	ENUE B	ALTIMO	DRE, N	ID 2	11224
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signatu	ure	A 2 2					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician Day Month Year 1031AM March TOR 22 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Hospita Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 06 13 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 219-05-0368 1 M 2 □ F Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits time MD Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 Was Decedent Ever in U.S Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by Black 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life_DO NOT use retired) Secondary (0-12) College (1-4or 5+) "Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname. Be arce 19a. Informant's Name/Relationship (Type. (Sheet and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau JBIVJ. .M. lotten 8030 HShtor 20207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory) or other 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ct'14: Ke, Balto., mD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death **Physician** Anythmi Cardine 10 minut disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Clastolic Medical Certification: To Be Completed 1 Yes 2 No 3 Probably 4 DURKnown Anenia 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an hyperkusion 1∐ Yes 2/14 25. Was ase referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ EN/Outpatient 3 ☐ DOA 27. Manne Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

or Attending Physician: The law requires that the death certificate be executed physician ar UDIVISION or Vital Records, P.O. Box 68760 attending p signed by the a certificate has b irector, page 2 sl within 24 hours after death To the Funeral Director: filled in by

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

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or Items

"natural"

th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical

Examiner must be notified at

State Registrar

Maghan

MAR 2 7 2007

29b. Signature and title of certifier

(Check only

Chikkley 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DEA 319914795 900

29d. Date signed (Month, Day, Year) March 22 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South Caton Avenue

29c. License number

MARYLAND PALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PII per MD G896 10/2/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11 10 AM **Physician** LASHER MARCH JOHN 200 /Medical 4c. County of Death 4b. City, Fown, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner timere Johns Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year | If Under 24 8. Date of Birth (Month, Day, Year) 5. Social Security Number Sex. 12 M 2□F **Funeral** Days Hours Bellivood Usual Residence of Decedent Yrs. 2 Director 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28s-f show other traumatic svent, I've Madical Exercities must be notified at 1 ☐ Yes 2 No Director MI 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21078 errac Funeral 000 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Myes 2 No Hyes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White Completed by 4 □ Divorced 3 Widowed 1,6b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) their eer Elementary/Secondary (0-12) College (1-4or 5+) 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be asher 10 ldred Joseph onawa 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a important: if item 27 is any injury or other training 00.00. 20b. Place of Disposition (Name of cemetery, crematory or other place) MC Terraca, Havie Naco Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Forest Hill 24/07 Evans Funeral Chapel-Belfir 3 MO 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Forcest Hill ALD 21050 21. Signature of Funeral Service Licenses Evans Fuscial Chapel-Cremation Services-Bel Air MELL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) -No/Medical Due to (or as 4 co equence of) Examiner cars 406 Carcinomo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physician and use as the burial-translt or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🔨 Due to (or as a consequence of) Physician/Medical use as the IF FFMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the e 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ete hes been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No certificete 1☐ Yes : After this certifice e funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 2 300 Certification: To 1 Tes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending To the numerical within 24 hours after death.

To the Funarsi Director: Aft 2 □ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide fo the Hospital 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 21 1 APRICHT T005 \mathcal{C} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Hore 2128 lerrence Vohas 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Lowry March L. 23 2007 4a. Facility Name (If not institution, give street and 4b. City, Town, or Location of Death County of Death ugie If Unde last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🔀 F 96 220-14-0920 September 3,1910 | West Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21222 USA 207 Cleveland Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes ŽŽ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 【XNo Specify: Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Accounting Clerk 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Victoria Romano John Lopez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6787 Woodley Road, Dundalk, MD. 21222 Richard L. Coleman Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 27, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cardens of Faith Cemetery Rosedale, Maryland 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. Melly 7110 Sollers Point Road, Dundalk, 21222 23a. art1. Enter the disease, or a mplications that caused the death. 20 not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1MON19 consequence of) Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2₽No 3 Probably 4 Unknown 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

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Pages 1 and 2 should be intentional be intentional Mental

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physician and s the burial-trans attending philor use as the ed by the a detached f signed b cate has been sig , page 2 should b funeral director. 24 hours after death Funeral Director:

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31. Date filed (Month, Day,

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law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

24a. Was an Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform 2 No 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Iniurv 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of perso pleted cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

Drive Baltimore, Mp. 21237 9Vare

3/23/07

State Registrar

		For State Registrar	State of Maryla		artment of H rtificate of L		, 0	JIENE eg. No. /	2007	nachl
hysicia	an	1. Decedent's Name (First, Middle, Last)	10014				2. Date of Dea Month	th Day	Year	3. Time of Death
/Medic		THELMA	TENY				MARCH	24	2007	11:35 A M
Examin	er	4a. Facility Name (If not institution, give s NORTHW EST HOSF)	TAL CENT	ER	,	LLSTOW			BALT	imore.
ineral ector				79 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 07/17/19	27 27	9. Birth Cou	place (State or Foreign ntry)
at at		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
a-f sh tifled	ctor	MD BALTIMOR	E E	BALTIMOR	E					1 ☐ Yes 2 ☐ No
be no	Director	10e. Street and Number	OT #110		10f. Zip Code		1		en of What Cou	ntry?
ns 23amust	Funeral	7 SLADE AVENUE A	2. Was Decedent Ever in	n U.S. 13. V	21208		ecify Yes or No-		S.A. 1. Race - Ameri	can Indian.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2【 No	n, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	
dical	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occupa kind of work done d DO NOT use retired,	ation Juring most of work	ting	16b. Kind	d of Business/Ir	ndustry
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rtic ev	10 B	SAMUEL		WIEN	ER	LENA			CC	HEN
raums		19a. Informant's Name/Relationship (Typ	e. Print)		ng Address (Street a					ŕ
thert		HYMAN LEVY / HUSE 20a. Method of Disposition		7 SLA b. Place of Dispo	DE AVENUE sition (Name of				RE, MD	
yoro		1 💆 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crer	natory or other place	03/26			,	,
any injur once,		21. Signature of Funeral Service License		22	. Name and Addres	s of Facility S	OL LEVIN	ISON		, INC. MD 21208
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the de						JVILLE	Approximate Interval Between
dician dical niner	miner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a corn	sequence of):	CARDIOU	ASCULAR	D15Ef	326		Onset and Death
as the bur	Medical Examin	resulting in death) Last	Due to (or as a cons	sequence of):						
sched for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3□	Ectopic pregnancy Other (specify)			23	d. Date of deliv Month	ery Day Year
ould be deta	ρ	Part II. Other significant conditions con	tributing to death but not in		nderlying cause give	n in Part I.	23e. Did tol			he cause of death? bably 4 Dunknown
completely filled in by the funeral director, page 2 should be detached for use	Completed		LLITUS.				24a. Was a autops perform	sy	prior to co death?	opsy findings available impletion of cause of
rector	Be	25. Was case referred to medical examiner?	ospital: 🔏		Othe	26. Place of Deat				
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ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - Arbuilding, etc. (Spe		eet, factory, office		28f. Location (St City or Town	treet and n, State)	Number or Run	al Route Number,
pletely fills	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
uoa v	M	29b. Signature and title of certifier	MYSICI	AN	29c. License	2321	m	ARCH	signed (Month,	2007.
61		30. Name and address of person who cor AVVERA ALL 31. Date filed (Month, Day, Year)	npleted cause of death (I	RISH .	Print) NORTI	OLP (HOSPIT	COAS	b (qui	21133
Sta Registra	_	MAR 2 7 2007	Mary As	Colle						

		1	State of Maryland / Dep 1- State Amend #26, perFD, g865, 3/27/07 TT Ce	artment of Health and Ment rtificate of Death	tal Hygiene 007 09605
	8	_	Decedent's Name (First, Middle, Last)		ate of Death Aonth Day Year
	Physicia /Medic		William levin		arch 24 2007 5:30 AM
	Examin		4a. Facility Name (If not institution, give street and number) Levindale Hebrew Home	4b. City, Town, or Location of Death Baltimore	4c. County of Death Baltimore
3*.·	Funeral Director		5. Social Security Number 222-10-5088 6. Sex 1 Age (In yrs. last birthday of the second security Number) 7. Age (In yrs. last birthday of the second sec) If Under 1 Year If Under 24 Hrs. 8. D Months Days Hours Min. NOV •	yonth, Day, Year) 4, 1923 9. Birthplace (State or Foreign Country) Willm., DE
	ō		Usual Residence of Decedent		10d, Inside City Limits
	arylan show	Ę.	MD Baltimore Baltimo		1 X Yes 2 □ No
	Ba-1	ecto		10f. Zip Code	10g. Citizen of What Country?
	with t	ă	10e. Street and Number 2434 W. Belvedere Ave.	21215	U.S.A.
	heath	era	11 Marital Status 12, Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Specify	Yes or No- 14. Race - American Indian, n. etc.) Black, White, etc.
36	within 72 hours after death with the Maryland ans. then "natural", or items 23s or 28s-f show the Madical Examinar most be notified at	by Funeral Director	1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican 1 ☐ Yes	Specify: White
9	2 hou	ted	(Give only highest grade completed)	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry
215	thin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	gr Public Housing
21	e filed wi al Hygian other th		12 Rea.	L Estate Agent/Mno	st, Middle, Maiden Surname)
and	od oth	Be C	Jacob Levin	Mollie M	
Maryl	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygians if Health and Mental Hygians Item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, Ire Macilian Examinant mant be notified at	2	19a Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Ro Box 2207, Wilmin	ute Number, City or Town, State, Zip Code) ngton, DE 19899
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health Important: If Item 27 I eny injury or other tra <u>9058</u> .		20a. Method of Disposition 20b. Place of Disposition cemetery, cr	position (Name of permator) Date Community 3/25/0	20c. Location - City or Town, State O7 Wilmington, DE
Baltin	permit. P Departme Importan eny injuri pnce.		21. Signature of Funeral Service Liver see	22. Name and Address of Facility Schoenberg Memoria	
	22200		23a Part Enter the disease or completions that caused the death. Do not e		
, E	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	elicatory Foi	Oncet and Death
7	/Medical		disease or condition resulting in death) a. Chronic Due to (or as a consequence of):	sfiratory fai Heart Failur	lure
	Examiner		Sequentially list conditions. b. Congestive	Heart Failur	e
	p #s	Iner	if any, leading to immediate Due to (or as a consequence of):		
	and and il-tran	Examine	Cause (Disease or injury that initiated events c		
8760,	cate be executed physician and tha burial-transit	dical E			
687	tificate ig phys	edic	0.		
Вох	andir use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1	B Ectopic pregnancy	23d. Date of delivery Month Day Year
	e death the atte	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)	
P.0	that the da led by the a detached t		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
of Vital Records,	uires tha signed I	Completed by	Chronic Renal disease		1 Yes 2 No 3 Probably 4 Unknown
CO	w requir	lete	anemia		24a. Was an autopsy findings available prior to completion of cause of
Re	The lay	mo	Jucos us		autopsy performed? prior to completion of cause of death? 1
tal		(D)	25. Was case referred to medical	26. Place of Death (C	
Ξ	Phyalcian: this certificand in director.	To B	examiner? 1	ient 3□ DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
0 L	ng Ph Iter th	no:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	y Work?	. Describe how injury occurred
Sio	Attending r death. ector: After by the fune	cati	2 Accident Investigation	M 1 Yes 2 No	Location (Street and Number or Rural Route Number,
Division	or Atl	Certification:	3 Suicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, State)
_	To the Hospital or Attending Phyalcian: within 24 hours aftar death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de control of the control of the pass of examination and/or and manner stated.	eath occurred at the time, date and place, and investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
	o the ithin 2 o the xmple	Mec	29b Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	F ₹ F 8		Man mo	DOD 63534	march 24 2007
	1.		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	march 24 2007 Reisterstown MD
	U			25 main Street	KeisTers Town MID
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
- 8	Regist	rair	MAP 2 7 2007	neade 1	

DHMH 17 Rev 1/2001

ORIGINAL

	1_ State	partment of Health and M Pertificate of Death	
	Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Beatif	Reg. No. 2. Date of Death 3. Time of Death
Physician /Medical	Louis Frank Loewner, Jr.		March 24, 2007 5:00 P
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	3840 Southern Cross Dr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Lochearn av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 215–28–6479 7. Age (In yrs. last birthd 7. Age (In yr	Months Days Hours Min.	Sep. 1, 1927 Maryland
pu »	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
Maryle f sho ied at	MD Baltimore Loche		1 ☐Yes XIXNo
vith the Ma t or 28a-f s be notified Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23a cust be ust be ral D	3840 Southern Cross Dr.	21207	U.S.A.
be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director		13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※X No Specify:	cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
d within 72 hours af giene. er than "natural", or the Medical Exami the Medical Exami	15. Decedent's Education 16a. De	ecedent's Usual Occupation	16b. Kind of Business/Industry
ed within 72 hou ygiene. her than "natura it, the Medical E Completed	(Specify only highest grade completed) (G	ive kind of work done during most of worki ie. DO NOT use retired)	ng ,
B E E E		ager/Meat Departm	
ould be fill Mental H arked out attic even attic even To Be	17. Father's Name (First, Middle, Last) Louis Frank Loewner, Sr.		(First, Middle, Maiden Surname) ppenheim
r and 2 should be fill of Health and Mental Hy filem 27 is marked oth r other traumatic eveni To Be (al Route Number, City or Town, State, Zip Code)
and 2 ealth a n 27 is	Florence B. Loewner / Wife 384	O Southern Cross 1	Dr, Baltimore, MD 21207
t. Pages 1 a tment of Hee tant: If Item	20a. Method of Disposition XIXBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition	sposition (Name of Determinatory or other place)	Date 20c. Location - City or Town, State
permit. Page Department of Important: If any Injury or once.	4 □ Donation 5 □ Other (Specify) Hebrew 21. Signature of Jung al Segrice Licensee	Comptory : 3/2	8/07 Reisterstown, MD hardt Funeral Chapel P.A.
perm Depa Impo any l			n Rd, Owings Mills, MD 211
Hicate be executed Special Examiner transit the burial-transit edical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	vest videnia	Interval Between Onset and Death Sudden
ath certif attending for use as lan/Me		3 □Ectopic pregnancy 5 □ Other <i>(specify)</i>	23d. Date of delivery Month Day Year
w requires that the de been signed by the should be detached i	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 No 3 Probably 4 Unknown
	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed? □ Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N
hysiciar his certif il director To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		ne 5 Residence 6 □Other (Specify)
ding Ph h. After thi funeral	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	e of 28c. Injury at 2 y Work?	28d. Describe how injury occurred
Ital or Attending Fis after death. Tal Director: After led in by the funer. Certification:	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I Medical Certification: To Be C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, drawn and manner stated.	eath occurred at the time, date and place, a rinvestigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
To the Complex	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	X awrence Aslomen M:	D 1016522	- March 26, 2007
			TO TORY OF THE
O. S.	30. Name and address of person who completed cause of death (Item 23a) (Type Lawrence Schow M, E	pe, Print)	- LAKE Dr. 21209

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #31, perDVR, g865, 3/27/07 TI Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 **Physician** Samuel Moore 5:00 AM 2007 /Medical Facility Name (If not institution, give streetand number) 4c. County of Death Examiner slumbia hwind toward er 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 9-36-4006 1 M 2 □ F 75 Yrs. Director 15 Usual Residence of Decedent 10a. State Town or Location 10d. Inside City Limits Show notified at 1 ☐ Yes 2 No toward Director lumbia or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ?7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Slac Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NΦT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) crobiologist permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Fether's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Prin 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 □ Donation 21. Signature of Funera Service Lie Balto., MU 21229 Tile. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC LUNG CANCER 6 MONTE /Medical Due to (or as a consequence of): Examiner CANCER MOSTATE (SYEHA) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed Division or Vital 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending To the nospinal within 24 hours after death.

To the Funeral Director: Aft investigation 1 ∏ Yes 2 ∏ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28768 Dui 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 ORLEANS ST IMSI A. KADEN BENGEN SOD MANDO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

MAR 2 7 2007

Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Vear) MAR 2 7

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Milhami mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Morris. Meredith

1106

32. Registrar's Signature

29c. License number

Levolution St.

D32 609

29d. Date signed (Month, Day, Year)

26107

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 🗎 1 - For State Registres Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Franklin Gerard Moyer 20 10:15 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Catonsville Commons Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 □ F 220-82-6223 Oct. 1962 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Fredonia Court 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🔯 No Specify: Specify: white 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lloyd Franklin Moyer, Jr. Margaret Koerber 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Moyer/Mother 403 W.Ordnance Road Apt 321 Glen Burnie MD 21061 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State west Arundel Crematory 3-22-2007 1.⊟Burial 2.X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Odenton, Maryland complications that caused the death po not enter the mode of dying, such as cardiac or respiratory arrest, Signature of Funeral Selvice Nicen 23a. Part I. Enter the disease, of con-shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final -irrhosi disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed

Physician /Medical **Examiner**

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To the Funeral Director; Aft

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State Registrar

injury or permil. Page Department Important: If any injury o

Physician

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iem 27 ia marked other than "natural", or items 23a or 28a-f ahow othar traumatic evant, the Medical Evantinst must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Menial Hygiene. Int: If item 27 ia marked other than "natural", or Itel

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

To the Hospital or Attending Physician:

pg

the Maryland

with

death

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 0 No 26. Place of Beath (Check only one)

2 No 1 🗆 Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №6 27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

Hospital: 28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work?

Other: 4 Jursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 🗌 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

D0056414

3-21-07

31. Date filed (Manth, Day, Year)

Sayed, MD, MPH 16 Fusting Avenue, Baltimore, MD21228

ess of per on who complet dyause of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

10724

ORIGINAL

DALVATER

31. Date filed (Month, Day, Year)

te Patryeut Pkwy Colombia,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	state of Maryla		artment of H tificate of L			ene g. No.2 A A 7	09611
ľ			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic	100	Laura Virg	ginia Ma	alone			March 14	Day Year 4, 2007	3:10 P M
	Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or	Location of Death		4c. County of Death	
2.000			Gilchrist Center			Towson		T	Baltimo	
5 30	Funeral Director		217-38-7399	2 ☐ F 7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 16	Year) 9. Birth Cou	place (State or Foreign ntry) Cyland
	yland now at		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	e Mai sa-f si tifled	Director	Maryland Baltimore		Timo	nium				1 □ Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	s 23a	ral	2029 Tree Lane	Man Danada A Francis I	16 140.1	2109		if- V N-	USA 14. Race - Amer	oon Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Was Decedent Ever in I Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2ሺ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	oecity Yes of No- o Rican, etc.)	Black, White Specify:	, etc.
21215-0036	2 hou	ed	15. Decedent's Educat	on	16a. Deced	dent's Usual Occupa	ation	1	6b. Kind of Business/li	ite ndustry
215	hin 72 e. an "na Media	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4or 5+)	(Give life. L	kind of work done of OO NOT use retired	luring most of worl)	king		
21	ed with	Com	8	n/a	Ho	memaker			Own Ho	ome
pu	be filed trail Hygid of other event, the	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M	laiden Surname)	
Maryland	should be and Mental s marked oumatic ev	J.	Joseph Seth	Corbin, J			Minerv			
Mai	d2sh than 7 is n traun		19a. Informant's Name/Relationship (Type.	•	l				City or Town, State, Z	
Ġ,	Health tem 27 pther tra		Patrick Malone/Sor 20a. Method of Disposition			d Manor C sition (Name of natory or other place			m, MD 211	• •
<u>o</u> E	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	ovar irom State		natory or other place rove Ceme	· · · · · · · · · · · · · · · · · · ·	7/07	Phoenix, Ma	rvland
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Sucreture of Emperal Service Licensee	Emnon	22	Name and Address	s of Facility		ney Valley	•
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of		ath. Do not ent	O W. Pado	nia Road	or respiratory arre	im, MD 210	193 Approximate
	Physician	1	shock, or heart failure. List only one of immediate Cause (Final disease or condition		NIC	card	omyd	patry		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					1003
	Lxaiiiiiei	-	Sequentially list conditions, b.	Ona to (or se s consa	ausens afte					
	rted nsit	nine	Sequentially list conditions, if dry, Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		quera e ory					
Ć	execu n and lal-tra	Examiner	resulting in death) Last	Due to (or as a conse	quence of):					•
68760,	tificate be executed g physician and as the burlal-transit	edical	d							
	ertifica ing ph e as th	Med	IF FEMALE:							
Вох	attend for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	If yes, outcome pf pregr 1□Live birth 2□Fe 4□Pregnant at time of	tal death 3□	Ectopic pregnancy Other (specify)			23d. Date of deli- Month	very Day Year
P.O.	t the c by the	hysi	9 Unknown	9□Unknown						
rds, F	The law requires that the death cert te has been signed by the attending toge 2 should be detached for use		Part II. Other significant conditions contril	outing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to s 2 No 3 Pro	10
or Vital Records,	e law re has bee e 2 sho	Completed by						24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
a	n: Th ficate r, pag		05 M						No 1 ☐ Yes	2 No
₹	Physician; this certific ral director,) Be	25. Was case referred to medical examiner? 1 Yes No	pital: 1 ☐ Inpatient 2 [TER/Outpatien	t 3 DOA Othe	r.	th <i>(Check only one</i> ome 5 ☐ Resider		Massaga
10	g Phy er this	٦. ٦	27. Manner of eath	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe how		my ruspe 4
ior	ath. or; Aff	atio	1 Natural 5 Pending investigation	(Wohli, Day Teal)	Injury		res 2 □ No			
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At I building, etc. <i>(Spe</i> c		eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only (Ch	an: To the best of my kr	nowledge, deati	occurred at the tim	ne, date and place	, and due to the ca	use(s) and manner as	stated.
	To the Ho within 24 To the For complete	Medical	one)	and manner stated.	and/01 III					
	Verit Con	2	29b. Signature and title of certifier	Lun		29c. License	S830	29	d. Date signed (Month	Day, Year)
•	7		30. Name and address of parson who some	leted cause of death /lto	m 23a) /Tune	Print)	J- 70J		narch!	("-/
	10		30. Name and address of person who comp	uez m	6701	N. Cher	les St	BATTA	no mo	21204
4	Sta Registr	- 44	31. Date filed (Month, Day, Year)	32 Pegistrar's Sigr	K L	acks 1				

		For State Registrar	e of Maryland		tment of H			iene g. n2 0 0 7	09612
1 2 3		Decedent's Name (First, Middle, Last)	·		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Deat	1	3. Time of Death
Physicia /Medic		Harvey Edward Mas	simore				March	25 2007	8:05 P. M
Examin		4a. Facility Name (If not institution, give street an			-	r Location of Death	1	4c. County of De	ath
	÷.	1211 North Main Stree			Hampst			Carrol	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. ia		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
Director		183-18-7517 Usual Residence of Decedent	63				March 0	2 1924	Maryland
yland		10a. State 10b. County	10c. City	, Town or Loca	ition				10d. Inside City Limits
Mar affal	ctor	Maryland Carroll	Ha	ampstea	.d				1 ☐ Yes 2 ☐ No
th the	lred	10e. Street and Number			10f. Zip Code		1(g. Citizen of What (Country?
23a ust b	Tal C	1211 North Main Stree	t Unit #1	101	21074	4	Un	ited State	es of America
ING 21215-0036 be filed within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. Ind other then "natural", or Itame 23a or 28a-f ahow avent, the Medical Examiner must be notified at	by Funeral Directo	1 Never Married 2 Married	Decedent Ever in U.Sed Forces? Yes 2 No s, Give or Dates: WWI	If \	as Decedent of H Yes, specify Cuba Tyes X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - An Black, Wh Specify: W	ite, etc.
21215-003 d within 72 hours giene. In then "netural", I'm Medical Exal	Completed	15. Decedent's Education (Specify only highest grade comple		16a. Decede	nt's Usual Occup nd of work done of NOT use retired	during most of work		16b. Kind of Busines	s/Industry
within 72 ene.	mc	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)		Mill Wor			Armco Ste	1
Iryland 2 should be filed ad Mental Hygis markad other matic avent, it	a l	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M		
ylano ould be Mental Markad o	To B	Harvey E. Masimore				Rosa G.	Brueh1		
100 " = - 3		19a. Informani's Name/Relationship (Type, Prince	1)	19b. Mailing	Address (Street	and Number or Ru	ral Route Number,	City or Town, State	Zip Code)
		Mrs. Linda C. Moler	(Daughter)	2222	Monocacy	Road, E	ssex, Ma	ryland 212	221
0 0		20a. Method of Disposition	20h PI	ace of Disposit	tion (Name of		Date	20c. Location - City of	or Town, State
caltimore, mit. Pages 1 ar partment of Hea portant: If Item y injury or other	,	1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Lake					•	, Maryland
Baltimo permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licensee	7						Directors, I
o 898 9		Standa L Le	mmer						yland 21133
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	on each line	. Do not enter	the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Offer and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	CS	NGO	296		A		10mm
/Medical Examiner		Du Du	ie to (or as a consequ	ence of):	V				
	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ue to (or as a consequ	ence off:					
ted	E I	Cause (Disease or injury		31,00 317.					
18760, cate be executed physician and the burial-transit	Examin	that initiated events c. resulting in death) Last Du	ie to (or as a consequ	ence of):					
8760 cate be e chysician the buris	dical	d							
687 ifficate g phys as the	edic			_				1	
Records, P.O. Box 6 The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	230. Was decedent pregnant	s, outcome of pregnar Live birth 2 🗌 Fetal		ctopic pregnancy	,		23d. Date of d	elivery
deat death	Cia	1 Yes 2 No	Pregnant at time of de Unknown		Other (specify)			Month	Day Year
IS, P.O.	hys	9 Unknown							
S, E es this gened be de	by	Part II. Other significant conditions contributing	to death but not resu	Iting in the und	lerlying cause giv	en in Part I.			to the cause of death?
COTC w require been si should I							1 □ Ye	s 2□No 3፫1	Probably 4 □Unknown
Records, he law requires t e has been signe age 2 should be o	ompleted						24a. Was an	v prior to	autopsy findings available completion of cause of
	Con						perform 1 ☐ Yes 2	ned? death?	
r Vital Pysician: The scartificate director, pag	Be	25. Was case referred to medical examiner?			100		th (Check only on	e)	
Phys r this ral dir	۵	1 Yes 2 No Hospital:		ER/Outpatient		4 🗆 Nursing H		nce 6 Other (Sp	ecify)
Affe une	0	1 Natural 5 Pending	(Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 ∐No	28d. Describe no	w injury occurred	
Division I or Attanding after death. Director: After	Cal	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At hor	me farm stree		163 2 110	28f. Location (Str	reet and Number or	Rural Route Number,
	Certification:	4 Homicide determined 286.	building, etc. (Specify,)	, , , , , , , , , , , , , , , , , , , ,		City or Town		
Div To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: 1 2 Medical Examiner: On	o the best of my know the basis of examinati manner stated.	vledge, death o ion and/or inve	occurred at the tin stigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
To the within 2 To the complet	₩.	29b. Signature and title of certifier	A		29c. Licens	e number	25	d. Date signed (Mo	nth, Day, Year)
- 51-0		1 Humo Kin	(a) Mus		D35	398	8	03-21	6-67
5		30. Name and address of person who completed	cause of death (Item	-	rinI)		Ceta varci	or vill	71157
Sta	to.	31. Date filed (Month, Day, Year)	32. Pribistrar's Signati		aver St	rept W	المالكاليق	J HUC	XIIV /
Registr		MAR 2 7 2007	Ballen .		will				
DHMH 17 Rev 1/20	001	11/11 × 1 2001	paragraph of	25	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21, **Physician** Thomas Reed Miller, Sr. MARCH Ø9:15PM 2007 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Anr. 4, 1923 6. Sex. 1 M 2 F If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland Months Days Hours Min. 212-12-2488 83 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location r 28a-f show notified at 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be n 28 Allegheny Avenue Apt. 1905 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) V.P. Manufacturing Maryland Glass 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reed Miller Helen O'Brien 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Helgas daughter 1616 Kurtz Avenue; Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Gardens: 3/26/07 Other (Specify) Timonium, MD 4 □ Donation 21. Signature of F rera S rvi e License 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS DAYS /Medical Due to (or as a consequence of) Examiner METASTATIC RECTAL CARCINOMA YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy 1☐ Yes To the Hospital or Attending Physician; illed in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one 21X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 ☐ Yes 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ILIA CEBALLOS M.D.

31. Date filed (Month, Day, Year)

D25886

7601 OSLER DRIVE TOWSON, MARYLAND 21204

1. Decedent's Name (First, Middle, Last) **Physician** Dorothy K. McGovern-Carr /Medical 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center 5. Social Security Number **Funeral** 176-18-7987 84 Director Usual Residence of Decedent 10a State 10b. County show notified at Director MD Baltimore 28a-f 10e Street and Number ö 1602 Hardwick Road item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must k Funeral 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than March 24, 2007 College (1-4or 5+) 17. Father's Name (First, Middle, Last) Benjamin Engle 19a. Informant's Name/Relationship (Type. Print) Department of Health as Important; if item 27 is any Injury or other trau Dottie McGovern (daughter) 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Immediate Cause (Final NONG **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. The Underly Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical as IF FEMALE 23b. Was decedent pregnant for in the past 12 months? 1 ☐ Yes 2 ☐ No Ö the 9☐Unknown 9 ☐ Unknown by ۵. Records, Completed by metastases has page 2 certificate Division or Vital 25. Was case referred to medical examiner? director, Be 1 ☐ Yes 💹 No Certification: To 1 Inpatient this 27. Manner of eath 28a. Date of Injury (Month, Day Year) After t Hospital or Attending 1 Natural 5 Pending investigation the Funeral Director: Af 2 Accident 6 Could not be determined 3 Suicide 4 THomicide 29a. Certifier (Check only one) and manner stated. the

31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death March 24 2007 2007 8:10 A M 4c. County of Death 4b. City. Town, or Location of Death Baltimore Towson If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Days Months 10c. City, Town or Location 10d. Inside City Limits 1 □Yes XXNo Towson 10f Zin Code 10g. Citizen of What Country? 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 No Specify: Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Bookeeper A & P Company 18. Mother's Name (First, Middle, Maiden Surname) Franks Emma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 Hardwick Road, Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Resurrection Cemetery 03/28/07 Bensalem, PA 22. Name and Address of Facility Ruck Towson Funeral Tome, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death uncrown. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe Yes 2 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 2 ER/Outpatient 3□ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tousantown Blod/BaltoMD MD/ 555 W. 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Meleady Glenn 700 10:44 MAK 77 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Marland Medical Center NIA BIDIT: more 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 12/18/1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours Min. 1**X**XM 2 □ F wv 75 236-44-6353 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Wells Avenue 21061 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. 1XXYes 2 No If Yes, Give Year or Dates: 1950-1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced 1954 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinest Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luther Hill Mildred Bates daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Michelle D'Ambrosio 15631 Thistle Downs Ct., Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gardens 3/26/2007 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. MO1357 1 Second Avenue SW, Glen Burnie, MD 21061 lanure 23a. Part1. Soter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myolardial Infarction ST Segment NOW-5 pays Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

Medical

the

Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked ott lury or other traumatic even

permit. Page Department of Important: If any Injury or

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

MD

burial-tran for funeral director, page 2 s this

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending 24 hours after death Funeral Director: filled in by To the within 2

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

Pelliune, MD. - Anthony

29d. Date signed (Month, Day, Year) 22 2007 21122

Booknore, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pellicone 22 South Greene Street Anthony 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Ralph	Eli Moxle		1- For State Registrar	State	of Marylar	nd / Depart <i>Certin</i>	ment of ficate of		nd Ment	al Hygi		g. No.	200	7 0961
	Physici	an/	1. Decedent's Nam								Date of Deat	Day	Year	3. Time of Death 0232 hrs
weak	al Exami		Ralph 4a. Facility Name (Eli		rley	III	b. City, Town, o	r Location o		farch 21,		ounty of Death	
				Vashington Me				Glen Burni				Anr	ne Arundel	
	Funeral Director		5. Social Security I		M 2 F	. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Day		Min	Date of Birt	,	Foreig	thplace (State or in untry) MD
	,	ŀ	Usual Residence o	of Decedent		<u> </u>		<u> </u>				., -		I dod I mide City I imite
	ow any		10a. State MD	Anne Aru	ndo]		own or Location Burn							10d. Inside City Limits 1 Yes 2 X No
	Maryland 28a-f show d at once	Director	10e. Street and Nu		inde £	010	Darn	10f. Zip Code			10	g. Citizer	of What Cou	ntry?
	the Misa or 2		1207 Sa	unders Wa	y			210	061			U.S.	Α.	
	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once,	Funeral	11. Marital Status 1 Never Marri	ied 2 Married	Armed For	T77		Decedent of Hi es, specify Cuba				14	. Race - Amer White, etc.	can Indian, Black,
	after de al", or ner mu	by Fu	3 Widowed	4 X Divorce	1 Yes If Yes, Give Year or Dates:	2 X No	1	Yes 2X No	specify:			Sp	ecify: Whi	te
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2-00	led wit Hygien other	하	17. Father's Name	(First, Middle, Last	t)			<u> </u>			st, Middle, M	laiden Su	rname)	
12	d be fil fental F arked event,	Be	Ralph Mo	oxley Jr	Tuna Print \		19h Mailing	Address (Stre			Spasar		or Town State	Zin Code)
2	2 shoul h and M 27 is m	٩	Mrs. Cari			other	0	Saunder				e, M	D 21061	-
- er	s I and of Healt If item		20a. Method of Dis	•	Removal from		ce of Disposi matory or oth	tion (Name of ce er place)	emetery,	March			ation - City or	
Him.	it. Page irtment prtant: ry or ot	-	Donation 5	Other Specify				1 Cemete		200				Park, MD
ű	Depirer in ju		Eth	7_		M0141	' 1	Second .	Avenu	e SW (Glen B	urni	e, MD 2	21061
	hysician /Medical		23a. Fart I. Enter the failure. List or	he disease, or com nly one cause on e		used the death. Do	o not enter th	e mode of dying	, such as ca	ardiac or res	spiratory arre	st, shock	, or heart	Approximate Interval Between Onset and Death
	xaminer		Immediate Cause or condition resulti		Cocaine Due to (or as a c	intoxicati consequence of).	on							Deaut
			Sequentially list co	onditions, b										
		Examiner	if any, leading to in cause Enter Und	erlying Cause	Due to (or as a c	consequence of):								
	ited d ansit		events resulting in		Due to (or as a c	consequence of):								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	X UNPENDED		#MENDED	28a-f, per	ME. 286	 6. 4/2/07	ידד		-			
760	icate b		IF FEMALE. 23b. Was decedent	t pregnant in the	23c. If yes, or	utcome of pregnar	ncy			pregnancy			ate of deliver	/ Day Year
Box 68760	leath certificate e attending phy for use as the b	sician/N	past 12 month	s?		τη nt at time of death		al death 3 ner (Specify)	Ectopic	pregnancy			onu .	yay (oa
	he deat y the at hed for	_≥\	Part II. Other sign	No 9 Unknow	a outling	vn death but not resu	ulting in the u	nderlying cause	given in Pa	rt i	23e Did to	pacco use	e contribute to	the cause of death?
0	ires that the signed by	Š	Part II. Other sign	inicant conditions	contributing to	deall but not resc	atting in the di	nderlying dadde	giverini		1 Yes		_	oably 4 🗸 Unknown
Ę	w require is been si should b	eted	<u> </u>				-				24a. Was a			topsy findings available completion of cause of
Division of Vital Records	he law ate has age 2 sl	Completed									perfor	med?	death? 1 ✔ Ye	es 2 No
<u> </u>	ician: The la certificate h	Be C	25. Was case refe examiner?		Danital -				of Death					
Į.	Physic er this ral dire	ျာ	1 Yes 27. Manner of Dea	2 No		patient 2 🗸 El	R/Outpatient 8b. Time of Ir		ury at Work	Nursing H	d. Describe h	Residenc		r.
2	ath.	Certification:	1 Natural	5 Pending	28a. Date o (Month, I	Day,Year)	nd 1:40		Yes 2 X		nk			
	or Atte fter des Directo	ifica	2 Accident 3 Suicide	Investiga 6 X Could no	00- 01	of Injury - At hom			building, et	c. 281	f. Location (S	treet and	Number or Ru	ıral Route Number, City
ءَ ()	spital hours a neral	Sert	4 Homicide	determin	ed (Specify)	found at								Burnie, MD
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2	Certifying Physic Medical Examine	er: On the basis of	examination and	, death occuri /or investigati	red at the time, o ion, in my opinio	date and pla in, death oc	curred at the	e time, date	e(s) and r and place	, and due to the	ed. le cause(s)
	To To	Mec	29b. Signature and	d title of certifier	and manner sta	ated.		29c. Licen	ise number			29d Da	te signed (Mo	nth, Day, Year)
	7		Patr	- Q 11	mia -	- Holle	Lus	0.0	.M.E.			March	21, 2007	
1				ress of person who		e of death (Item 23 nt Medical Ex		111 Penn S	Street. Ba	Iltimore.	MD 2120			
	•	tate	31 Date filed (Mor		-	gistrar's Signature								
	Regis		M	AR 2 7 20	107	qua so	Apre					-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 Physician Month Petrina Napoli 24, March 11:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Martin's Home Catonsville Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Yrs 214-38-9766 Director 89 5, 1917 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f shiner must be notified 1 ☐ Yes 2 ☑ No Director Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Maiden Choice Lane 21228 USA death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or item: Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give X Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: White 3 Widowed 4 Divorced 'natural", event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) none Homemaker Family Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mariano Napoli Michelina Pecora ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Joseph Napoli / Brother 230 Lyndale Avenue, Baltimore, Maryland 21236-4220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 3/27/2007 Baltimore, Maryland 21. Simeture Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Dement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examine be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□ Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury death. 2 Accident 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the

2

State Registrar SAMBANDAM 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

WILKENS AVE BALTIMORE, MD 21229 3455 32 Registrar's Signature

29b. Signature and title of ce

D21649

29d. Date signed (Month, Day, Year)

March 26, 2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2007 Year **Physician** 21 10:55a M March Oswin Winifred May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner N/A Baltimore Keswick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 JF England 220-28-1729 April 9, 1921 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State ir than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ✓ Yes 2 No N/A Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21209 11 Sugarloaf Court #202 USA Funeral filed within 72 hours after deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced White Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiene. Administrative Assistant Rental Agent +4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 end 2 should be file Deperment of Health and Mental Hy Importent: If Item 27 is marked other any liquy or other traumatic event ODEs. Be Dorothy F. Medhurst Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 Sugarloaf Ct. #202 Baltimore, Md. 21209 Ms. Lesley J. Oswin/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Towson, Md. Hillton Service Co. |3-23-07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Fugeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DNEUmonia **Physician** ACUTE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine signed by the ettending physicien and a be deteched for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? coronmy Artery disease, obstructure 1 Yes 2 No 3 Probably 4 Unknown cete hes been sig page 2 should b CArotid Artery disease, Dia betes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed with neuropathy and gastroge Aresis 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeret Director; After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending 1 TYes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MArch 22, 2007 1)25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Rults . md 21205 6701 G BINC Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 7 2007 Registrar

			For State Registrar		partment of Health and I pertificate of Death		iene 2007	09620
			Decedent's Name (First, Middle, Last)			2. Date of Deat	th	3. Time of Death
	Physicia		Donna Marie	Olsen-Kopp	ana	Month	21 2007	0255M
1	/Medio Examin		4a. Facility Name (If not institution, give street		4b. City, Town, or Location of Death		4c. County of Death	1
	Examin	٠.	106 DICKENS	St.	GIEN BU	rpire	17 1	<i>†</i>
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Year) 9. Birth	nplace (State or Foreign
>.	Director		124-44-9849 ¹□M:	21X F 48 Yrs.	leonals Days Floors IIII	Sept. 1	0,1958	NY
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	anyla shov	_	MD Anne Arunde					1 ☐ Yes 2 ☑ No
	he M	Director		dien but	10f. Zip Code	1	Og. Citizen of What Co	untry?
	with t		10e. Street and Number 106 Dickens Street		21061		U.S.A.	,-
	eath	Funeral		Vas Decedent Ever in U.S. 13	I. Was Decedent of Hispanic Origin? (S		14. Race - Amer	rican Indian,
	Iter d	Š	A A	med Forces?	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White	•
336	irs af	by	If	Yes, Give ear or Dates:	1 Yes 2 No Specify:		Specify: Wi	ite
ğ	filed within 72 hours after death with the Maryland Hygiens Hygiens than "natural, or Items 23s or 28s-f show the the Medical Examinar must be notified at	Completed	15. Decedent's Education		edent's Usual Occupation we kind of work done during most of wor	rking	16b. Kind of Business/I	ndustry
215	hin 7	ple	(Specify only highest grade com	college (1-4or 5+)	DO NOT use retired)	N///g		
21	giene giene grenth	Con		2 Cont	tract Specialist		Governme	ent
힏	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)		-7.0-2	ne (First, Middle, i		
<u>X</u>	should be ind Mental s marked o umatic eve	ဥ	Robert Olsen			Appanasf		
Maryland 21215-0036			19a. Informant's Name/Relationship (Type, F		iling Address (Street and Number or Ru			
o)	1 and 2 Health a tem 27 l		Mr. Mark Koppana/ Hu 20a. Method of Disposition	1SDATIC LUO 20b. Place of Dis	Dickens Street GL	Date	20c. Location - City or	
altimore,	Pages nent of hont: If ite		1 ☐ Burial 2 XCremation 3 ☐ Remove	val from State cemetery, ci	rematory or other place) Mar	ch 22,	Stevensvill	
≣	t. Pa rtmer rtent:		* 4 □Donation 5 □ Other (Specify) 21. Signature of Uneral Service Licensee		ake Cremation 2 22. Name and Address of Facility Si			
Ba	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Signature of Contain Styles Licensee		l Second Avenue SW			
			23a. Part1. Enter the disease, or complication	ns that caused the death. Do not e				Approximate
ļ			shock, or heart failure. List only one ca Immediate Cause (Final	use on each line.	1' An	1.41	4.0.4.0-	Interval Between Onset and Death
F	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	CALAR TIVIT	rigth	cot i fa	
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		ler	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
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õ	ntifica ing ph e as t	Med	IF FEMALE:					
Box	death certific e attending p od for use as	an/l	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of deli Month	very Day Year
о. В	that the death certific ed by the attending p detached for use as	Physician/Me	1 □Van a □Na	I∏Pregnant at time of death 5 □Unknown	i ☐ Other (specify)			
۵.	hat the deby detac		Part II. Other significant conditions contribu	iting to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Division of Vital Records,	s Cre	Completed by	CorobrovAscula	· Accident	Muttofe	1 □ Y	es 2 No 3 Pr	obably 4 Unknown
Ö	w require been signature should b	etec	Zala azir)	y y	24a. Was a	n 24h Were au	topsy findings available
že	has has ye 2 s	mpi	Scierosis			autop: perfor	med? prior to death?	completion of cause of
a			25. Was case referred to medical		OF Place of Do	1 ☐ Yes ath (Check only or		2□ No
Ĭ	Attending Physicien: The lav r death. ector: Atter this certificate has by the funeral director, page 2	o Be	examiner? 1 X yes 2 No	tal: 1 ☐ Inpatient 2 ☐ ER/Outpati	Other	-	ence 6 ⊡Other (Spec	cify)
o	Phy or this oral d	: To		Ba. Date of Injury 28b. Time	of 28c. Injury at		ow injury occurred	,,
on	nding ith. :: Afte	ţ	1 Accident 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	M 1 ☐ Yes 2 ☐ No			
<u>Nis</u>	Attendi ar death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28	Be. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Town	treet and Number or Ru n, State)	ral Route Number,
ā	tal or A s after al Dire ed in by	Cert		, , , , , , , , , , , , , , , , , , , ,				
	e Hospita 24 hours s Funerel etely filled	edical	29a. Certifier (Check only 1 Certifying Physicie 2 Medical Exeminer:	n: To the best of my knowledge, de On the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occurred	e, and due to the curred at the time, d	ause(s) and manner as late and place, and due	stated, to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funarel Director: After th completely filled in by the funeral	Medi	one)	and manner stated.	Loo times sumbon		20d Date signed (Month	h Day Voss)
	with to con		29b. Signature and title of certifier	DEBUTE	D0605	4	3/23	17
,	1		Ulllent	43 mo			-/	, •
1			30, Name and address of person who comple	ered cause of death (Item 23a) (Typ	DOGOS e, Print) 1095 An	REVICA	510	35
	-C+	to	31. Date filed (Month, Day, Year)	Registrar's Signature	ack!			
	Sta Registr		MAR 2 7 2007	placer is 19				

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 ours after death. neral Director: A filled in by the fu

Baltimore, Maryland 21215-0036

within 24 hours at To the Funeral D

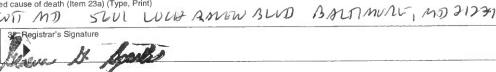
6+1 State

Registrar

DENEWAL N. SWIT MD 31. Date filed (Month, Day, Year)

Amerin 1. 1 hopmo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29b. Signature and title of certifier

29c. License number

D15135

29d. Date signed (Month, Day, Year)

MMC4 22, 2007

			For State Registrar	State of Ma	ryland /	-	rtmen tificate				R	eg. No.	007	09622
	Physici	an	1. Decedent's Name (First, Middle, Last)	0.64	K.	00	165	•			. Date of Dea Month	Day	2007	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give s		N -	1 ~			Location o		<i>ranch</i>	4c. Co	unty of Death	
	E Admin		Northwest Hospita						la11st				altimor	
	Funeral Director		5. Social Security Number 6. Sex 1085–46–1169	M 2 F 7. Age	(In yrs. last b	Yrs.	If Under Months	Days	If Under a	Min. J	. Date of Birth (Month, Day une 22	Year) 195:	3 9. Birthp	olace (State or Foreign ntry) NY
	ס		Usual Residence of Decedent		to- City T-								1,	Od. Inside City Limits
	Aarylar F ehow	ō	MD 10a. State 10b. County		10c. City, To Ba	1tim							•	1 1 Yes 2 No
	with the A 3a or 28a-1	Funeral Director	10e. Street and Number 7103 Rudisill C	ourt			10f. Zip	Code 212	244				of What Cour	ntry?
036	d within 72 hours after deeth with the Maryland Jiene. I then "natural", or iteme 23a or 28a-f ehow The Macinal Examinar must be natilised at	ρ	11. Marital Status 1 Never Married 24 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		81	Vas Deced f Yes, spec	ify Cubar	spanic Origin, Mexican	gin? (Specif i, Puerto Ric	fy Yes or No- can, etc.)		Race - Americ Black, White, pecify: Bl	
21215-0036	within 72 hc ene. then "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			(Give	DO NOT us	rk done d se retired,	uring most	t of working			of Business/In 1th Caj	
and 21	t be filed w ntal Hygier ed other th	Be	12 17. Father's Name (First, Middle, Last) James Mitchel	1			Nurs	se	18. Mothe	er's Name (F	First, Middle, alrclo			
Maryland	s 1 end 2 should be filed f Heelih and Mental Hyg Item 27 ie marked othe other traumatic event,	ဥ	19a. Informant's Name/Relationship (Ty.) Jamal King / S	oe, <i>Print)</i>	15	9b. Mailin 151	g Address Sumne	(Street a	nd Numbe 7enue	or or Rural F , Spr	noute Number ingfie	r. City or To 1d, M	own, State, Zij A 0110	3 Code) 3
altimore,	Pages 1 end 2 nent of Heelth int: if item 27 i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🗓 R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place cemes Frede Memor	rick	natory or o	ther place		rch 29	9, 200		tion - City or To aten Is	own, State sland, NY
Balti	permit. Pages Depertment of 6 important: if its eny injury or o		21. Signature of Funeral Service License	6. Morest	iall		Name an	d Addres Les I East	s of Facility For	evens t Ave	Funer nue, B	al Ho altim	me Inc ore, M	D 21230
8760,	Physician and physician and physician and physician and physician and the burial-transit	Ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a	LTIPLE a consequence MALL a consequence	e of): CE e of):	RA	N	MET	ASTA	515		149	Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificete be executed ate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pi Other (sp					230	d. Date of deliv	ery Day Year
	uires that signed b ld be deta	ρ	Part II. Other significant conditions con HYPERTENS I					ause give	en in Part I			bacco use ′es 2□1		the cause of death?
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Vita	Physician: Th this certificeteral director, pag	Be	25. Was case referred to medical examiner?	lospital:			2	Othe	200		Check only o		70	
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Division	5 € <u>5</u> ⊆	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.		farm, str	eet, factor	y, office		28	St. Location (S City or Tow		Number or Rur	al Route Number,
	I 4 II @	Medical C	29a. Certifier 1 Certifying Thy (Check only one)	ner: On the best and manner sta	examination		vestigation	, in my o	pinion, dea		at the time,	date and pl	ace, and due t	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	MA	•		29	c. Licensi	number	n		29d, Date s	signed (Month,	Day, Year)
,	9		30. Name and address of person who co	ompleted cause of d	eath (Item 23)	a) (Tvne	Print)	yd	113	1		/7,1145C	11 / 73	2001
	D		RAYNOLD DEPER	TRE 310	20 LORD	BAL	TIMO	LE DI	R.#1	10	BALTI	MORE	MD	21244
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teven A. Piepiora	1	State of Maryland / Department of Health - For State Certificate of Death	and Mental Hy	ygiene Reg.	200	7 09523
Physician Medical Examine	1/	Steven A. Piepiura		2. Date of Death	Day Year	3. Time of Death 1422 hrs
and the second	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town 309 Glenwood Road 4b. City, Town Bel Air	n, or Location of Death		4c. County of Death Harford	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		_	(MM/DD/YYYY) 9. Bir	thplace (State or
Director		320-15-3790 1XM 2 F 19 Yrs. Months	Days Hours Min.	August	4,1987 00	untry) M D
any	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			•	10d. Inside City Limits
A . 1	5	MD Harford Belf	tir			1 Yes 2 No
th the Maryland 23a or 28a-f she notified at once	Director	10e. Street and Number	de	10g	Citizen of What Cou	ntry?
with the			مار کا کا of Hispanic Origin? (Sp		14. Race - Amer	ican Indian, Black,
death or item	Funeral	1 Yes 2 No	uban, Mexican, Puerto	Rican, etc.)	White, etc.	د ل
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5-0036 ited within 7 Hygiene.	를-	17. Father's Name (First, Middle, Last)	18 Mother's Name	e (First, Middle, Ma	Clectri	cal
215- be filed and Hyger ked of	a B	Gerald C. Piepipra	Dene	ise J	. Steve	
21 ould outd		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (s	Street and Number or I	Rural Route Numb	er, City or Town, State	e, Zip Code)
alt m	-	20d. Method of Disposition 20b. Place of Disposition (Name of Disposition)	of cemetery,	Date	20c. Location - City or	Town, State
Pages 1 ent of F nt: If i		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	rel-BelAir 4	11/07	Forest Hi	U.MD
Baltimore, permit Pages 1 a Department of He Important: If ite injury or other ti	ŀ	21. Signature of Funeral Service Licensee 22. Name and Add	dress of Facility 3 U	emport D	111	HITMO ZIOS
Physician	+	23a. Part I. Enter the disease, or complications trat caused the death. Do not enter the mode of d	lying, such as cardiac		t, shock, or heart	Approximate Interval
/Medical		failure. List only/one cause on each line. Immediate Cause (Final disease a. Intraoral gunshot wound				Between Onset and Death
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30x 6876(death certificate e attending physic for use as the b	ian/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregna	ancy	Month	Day Year
Box 6876 for death certificate the attending phy led for use as the beat for use as th	Physician/M	1 Yes 2 No 9 Unknown g Unknown				
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Divisior spital or Attend hours after death nneral Director: y filled in by the	Certification:	Accident investigation 28e. Place of Injury - At home, farm, street, factory, or 28e. Place of Injury - At home, farm, street, factory, or 28e.	ffice building, etc.	28f. Location (St or Town, St	treet and Number or R ate) Rd, Bel Air, MD	ural Route Number, City
Di Hospital 24 hours a Funeral I		4 Homicide determined (Specify) Back yard 29a Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the tire	me date and place an			nted.
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician properties of the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautiful or the funeral director, page 2 should be detached for use as the beautiful or the funeral director, page 2 should be detached for use as the beautiful or the funeral director, page 2 should be detached for use as the beautiful or the funeral directory.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated.	pinion, death occurred	at the time, date a	and place, and due to t	he cause(s)
F 8 5 8	Me	29b. Signature and title of certifier 29c. L	License number		29d Date signed (M March 25, 2007	
\ \		Therdre M. King Thy us.	O.C.M.E.		Water 25, 2007	
W		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Pen	n Street, Baltimo	re, MD 21201		
Sta		31. Date filed (Month, Day, Year) MAR 2 7 2007 MAR 2 7 2007				
Registr	10.14	WAR & LOUI ALEMENT IN THE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 21, **Physician** 2007 Debora 1:30 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4162 Hollins Ferry Road Lansdowne Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sep. 27, Year 953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 ☐ F **Funeral** 220-70-1680 53 Maryland Vrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Baltimore Lansdowne 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4162 Hollins Ferry Road 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specific Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be intented to Health and Mental int: If Item 27 is marked or Walter J. Gentila Grace B. George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4162 Hollins Ferry Rd., Lansdowne, MD 21227 19a. Informant's Name/Relationship (Type. Print) Joseph T. Pfofilio, Srl. Department of Health ar Important: If Item 27 is any injury or other trau Husband 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Westery, Appendix Per place) 20c. Location - City or Town, State Donation 5 ☐ Other (Specify) 3-23-2007 Crematory Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hamonds Ferry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. D not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) beto Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner Due to (or as a consequence Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 month 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autonsv perform 2 2

To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buntal-ran Box 68760, Division or Vital Records, P.O.

Certification: To

Medical

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

20 No

5 Pending investigation

6 ☐ Could not be

nd address of person who con

determined

1 ☐ Yes

27. Manner of Death

2 Accident 3 Suicide

4 ☐ Homicide

29a, Certifier

32. P bistrar's Signature

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

6 ☐Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

301 St.

28d. Describe how injury occurred

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence

ORIGINAL

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated.

29c. License number

1 Tes

2 No

1665

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LeRoy Pumphrey March 100 PM 2007 /Medical 4c. County of Death . Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Burne Glen Daltimore Washington Medical Center Home Arunde If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 220-22-9246 80 11, Director July MD Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov ?7 Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8662 Veterans Hwv. Millersville U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operating Engineer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Pumphrey Louise Stinchcomb ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Mrs. Shirley Pumphrey/ Wife 8662 Veterans Hwy. Millersville, MD 21108 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 28. 1 Burial 2 ☐ Cremation 3 ☐Removal from State Glen Haven Mem. Park 2007 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Singleton Funeral Home, P.A. Second Avenue SW Glen Burnie, MD 21061 MO1357 23a. Part1. Ele disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 21/2 YEAR **Physician** MOM SMALL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence off The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buna Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Director: After this in by the funeral dir 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Vatural Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at 29a. Certifier 1 🖳 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007 address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

10030

31. Date filed (Month, Day, (Year)

501

32. Registrar's Signature

Hospital

sen Busice

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 12:00 A M Dwight Payne 03 23 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3645 Raymond Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 218-56-0213 52 08/10/1954 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 1 X Yes 2 □ No is 1 and 2 should be filed within 72 hours after death with the Man of Health and Mental Hyglene.
The ten 27 is marked other than "natural", or items 23a or 28a-f she there traumatic event, the Madrial Examiner must be notified. Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 3645 Raymond Avenue 21213 USA Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify 3 3 Widowed 4 Divorced Áfrican American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) addiction services counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John H. Payne Sylvia Brown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3645 Raymond Avenue; Baltimore, Maryland 21213 Dawn Payne / Daughter 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If Iter
any Injury or off 03/26/2007 Baltimore, Maryland Metro Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached 1 Tyes 2 □ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of death?
1 ☐ Yes 2 ☐ No autopsy performe 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only, one) director Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 2 1 TYes 1 Inpatient 2 ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident ours after death neral Director: / filled in by the f 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

MAR 2

weight Cour Courses

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

7 2007

32. Registrar's Signature

07-02211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Wanda Proffitt Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 22, 2007 Year 1700 hrs WANDA PROFFITT MAY Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A Baltimore 740 Poplar Grove St If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Foreign Country)I1<u>1inois</u> Funeral Hours Months Davs Director 20,1954 185-46-7510 52 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County E, 10a, State 1 V Yes 2 No N/A Baltimore Maryland or items 23a or 28a-f shomust be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 740 Poplar Grove Street 21216 U.S.A. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. White Armed Forces? Never Married 2 Married 2 / No Yes 2 No If Yes, Give Yee specify: Specify: 4 Divorced 3 Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) d other than "; American Trade Bindery 0 Printer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Be Thomas Jones 19a. Informant's Name/Relationship (Type, Print) Maryland 21230 item 27 is 2815 Washington Blvd., Baltimore. Richard Proffitt (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Bayview Crematory Burial 2 Cremation Removal from State Ħ 03-24-07 Baltimore, Maryland permit. Page Department mportant: Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licens McCully-Polyniak Funeral Home P.A. 37 F. Patapsco Avenue, the mode of dying, such as cardiac or respiratory Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not ent **Physician** Between Onset and failure. List only one cause on each line Death /Medical a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequenca of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): avents resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and trans ca UNPENDED AMENDED ned by the attending physician detached for use as the burial Physician/Medi 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o signed by 1 Yes 2 No 3 Probably 4 V Unknown <u>م</u> σ. Completed 24b. Were autopsy findings available Records, 24a Was an has been autopsy performed death? page 2 sl Yes Yes 2 V No certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital director, Be Other₄ Residence 6 V Other: Scene examiner? Nursing Home 5 FR/Outpatient 3 Inpatient 2 this ٩ 1 Yes No 28d. Describe how injury occurred funeral 28c. Injury at Work? 28a. Date of Injury (Month, Dey, Year 28b. Time of Injury After 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Division death. Director: Pending Investigation 24 hours after dea E Funeral Directo etely filled in by the 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Could not be Suicide (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 completely Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) To the within 2 To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certified March 24, 2007 O.C.M.E. 30. Name and address of person who completed causa of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 32 Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

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			Registrar 1. Decedent's Name (First, Middle, Last)		Reg 2. Date of Death	, No.	3. Time of Death
	Physici	ian	Betty Jo Richardson		Month	Day Year	
	/Medio			o. City, Town, or Location of Death	March	20 2007	10:20 P
	Examir	ner	St. Agnes Hospital	Baltimore		4c. County of Death	
	Funeral				8 Date of Birth		place (State or Foreign
и	Funeral Director			onths Days Hours Min.	8. Date of Birth (Month, Day, Y		intry)
			Usual Residence of Decedent		_02/25/1	920 UK	lahoma
-	how =		10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
3		cto	MD Baltimore Catons	sville			1 ☐ Yes 2 XNo
4	me 23a or 28a-1 ehow	Director	10e. Street and Number	Of. Zip Code	100	. Citizen of What Cou	ntry?
1	23	al	709 Maiden Choice Lane Rm. #6202	21228		United S	States
9		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was	Decedent of Hispanic Origin? (Specs, specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - Ameri Black, White	
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מ פ	Hygi ther int.		12 6 Scho	ool Teacher 18. Mother's Name	(First Middle Ma	Education	1
Maryland 21215-0036	antal c e d o	o Be	Leon Heathman Watson		tson Dar		
aryla	mark mark	2		ddress (Street and Number or Rural			Code)
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စ် ု	A E E		20a. Method of Disposition 1 Rurial 2 Orcemation 3 Page State 20b. Place of Disposition cemetery, cremato,			c. Location - City or T	
P S	5 = 5		TEDUNAL E LACIONALION SENSITION STATE				
Baltimore,	ortant njury		4 ☐ Oonation 5 ☐ Other (Specify) BayView (21 Signatur of Funeral Service Licenses 22. Na	mo and Address of Easility		Baltimore	
Ba	Department of the control of the con		100000	Hu	bbard Fu	neral Home	e, Inc.
			23a. Part Nenter the disease, or complications that caused the death. Do not enter the	07 Wilkens Avenue	, Baltin	ore, Mary	Land 21229
			snock, or near tallure. List only one cause on each line.		respiratory arrest		Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	l infaction	7		hours
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760, /	ysicien and	call	•	A 100 mg	dicag	21	years.
X 68	attending phy	edic			003 600		
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n f	d for	icla	in the past 12 months? 1 \[\text{Vec} 2 \] \[\text{Imon} \] 4 \[\text{Pregnant at time of death} \] 5 \[\text{Oth} \]	opic pregnancy ner (specify)		Month	Day Year
9	by the	hys	9 □ Unknown				
ords, P.O	been signed by the s	y P	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
בקוני קוני	os or d blu	ba H	Algheimers diseas	<u>-e</u>	1 🗀 Yes	2 □No 3 □ Prot	pably 4 Unknown
Vital Records,	s bee	Completed	End stage renal	disease	24a. Was an	24b. Were auto	onsy findings available
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a a	tifice tor, p	0	25. Was case referred to medical	26. Place of Death	Chack and and	Ho 1 □ Yes	2□ No
Z	efter death. Director: After this certifice I in by the funeral director, if	To B	examiner? 1 Yes 2 10 Hospital: 1 Ultratient 2 ER/Outpatient 3	1 000		e 6 ⊡Other (Specil	LI .
0 4	er th		27. Manner death 28a. Date of Injury 28b. Time of		d. Describe how		y/
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UIVISION Lor Attending	ecto by th	2	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, f	factory, office 28	f. Location (Stree	t and Number or Rura	Al Route Number,
בֿ בֿ	s efte	Certification:	building, etc. (Specify)		City or Town, S	itate)	
pani	within 24 hours efter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2		29a. Certifier Check only 2 Medical Examiner: On the best of my knowledge, death occ	urred at the time, date and place, an	d due to the caus	e(s) and manner as s	tated.
Ĭ	in 24 he Fi	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	gation, in my opinion, death occurred	at the time, date	and place, and due to	the cause(s)
Tot	within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
			pedels MD	P20965	M	auch, 20	1,2007
	18		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	^	0	
	10			ous Caron	Aveny	e, Bal	Home
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	M .		(
	Registra	di	MAR 2 7 2007 Meeues St. April	MAL			

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			1 - For State Registrar	State of Ma		artmen			ind M		giene Reg. No.	007	096	29
	Physic	ian	Decedent's Name (First, Middle, Last)							2. Date of Dea Month	ith Day	Year	3. Time of D	eath
	/Medi	cal	Jean Norma Radue			1				March 2		07	13:56	М
1	Examir	ner	4a. Facility Name (If not institution, give s 7306 Cheryl Avenu				own, or 195vi	Location of	t Death			unty of Death		
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthda) If Under	1 Year	If Under 2		8. Date of Birth (Month, Day			nplace (State or Funtry)	Foreign
	Director		218-28-6580	M 2[XF	75 Yrs.	Months	Days	Hours	Min.	Sep. 2	5, 193	31 Ma	ryland	
	and *		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or	ocation							10d. Inside City	Limite
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	r 28e	rec	Maryland Baltimor	9	Kingsv	10f. Zip	Code				10g. Citizer	of What Cou	untry?	
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	r dea	Funeral Director		2. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Deced	ent of Hi	spanic Orig n, Mexican,	in? (Spe Puerto l	cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
36	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28e-f show he Madical Examinar must be notilited at	by Fi	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2		Specify:				ecify:		
21215-0036	2 hou	ted	15. Decedent's Educ	ation	16a. Dec	edent's Usua	I Occupa	ition			16b. Kind	of Business/I	ite	
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Maryland	ould be fill Mental H arkad oth	Be	17. Father's Name (First, Middle, Last)							(First, Middle, stella 1		mame)		
Ž	should Id Mei mark matic	၉	Warren James Cage 19a. Informant's Name/Relationship (Type	e Print)	19h Mai	ling Address	(Street a			l Route Numbe		um State 7	in Codel	
	nd 2 s lith ar 27 is r trau		John L. Eaton/ So	-									ia 17302	2
Je,	of Heatitem	1 1	20a. Method of Disposition		20b. Place of Disp cemetery, cr					ate		ion - City or 1		
Ē	Page nent c ant: If ury or		1XX Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Bel Air				3-27-	-07	Bel A	ir. Ma	ryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any njury or other traumatic avant, the Madical Examiner must be notified at once.		21. Signature of Funeral Service License	/						ne, P. A				
_	205 g g		15gr 111, 11/1	الر		1317 C	'okes	bury	Road	. Abino	rdon.	Maryl	and 2100)9
	Physician /Medical Examiner		23a. Part. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ACUTE	4	SDIAL			ET/	r respiratory ari	est,		Approximate Interval Betwee Onset and De	
760, /	ate be executed thysicien and the buriat-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CARDI	consequence of):	9771Y		0107				,	O YEAR	25
687	ficate phys s the	edicai	d.											
P.O. Box (or Attending Physician: The law requires that the death certificate be executed title death. Director: After this certificate hes been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	□Ectopic pre □ Other (spe		10	_		23d	Date of deligion	very Day Yea	ar
	s that ned b e deta	by Pt	Part II. Other significant conditions cont	nbuting to death but	not resulting in the	underlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of dea	ith?
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Division of Vital Records,	The law re ete hes ber page 2 sho	Completed								24a. Was a autops perfor	med?	4b. Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings ava ompletion of cau	ailable se of
/ita	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?				-		of Death	(Check anly or				
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5	ding h. h. After funer	tou	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	M 28	Bc. Injury Work	at ? es 2⊠N		8d. Describe h	ow injury oc	curred		
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	y - At home, farm, s (Specify)					8f. Location (Si City or Town	treet and No.	umber or Rui	ral Route Numbe	Γ,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical (29a. Certifier (Chack only one) Certifying Physical Certifying Physical Camping Physical Camping Physical Certifying Physical	cian: To the best of or: On the basis of a and manner state	examination and/or i	ith occurred a nvestigation,	it the time in my op	e, date and inion, death	piace, a	and due to the cood at the time, d	ause(s) and ate and pla	d manner as ce, and due	stated. to the cause(s)	
)	To t To t	Σ	29b. Signature and title of certifier	ano		29c.	License D 3	number	,	2	9d. Date si	gned (Month 6/20	Day, Year)	
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	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 7 2	00 0 11										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** RO LEANOR JANE 0430 AM /Medical b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ESTMINSTER HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1□M 2\ F Yrs. Director 079-14-4640 89 23, 1917 APR New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Director notified MD Carroll Westminster 28a-f 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? a or 300 St. Luke Circle 21158 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Ь Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ 3 √Widowed 4 ☐ Divorced 42-45 White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Secretary</u> Higher Education permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles **Orange** Warner Grace Edna ဂ္ဂ Cator 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Roy - daughter 3404 Hartwell Court, Falls Church, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 3/26/2007 Baltimore, MD 21. Signature of Funeral Service Leanseen H. Williams ²² Name and Address of Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART BNGESTIVE Physician /Medical **Examiner** NELIMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 🗷 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUPERTOR

32. Registrar's Signature

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Even It Span

BOWIE, MD

DHMH 17 Rev 1/2001

State

Registrar

KANU

31. Date filed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2.3.30 perPHYS. G866.4713/07 WS

State of Maryland / Department of Health and Mental Hygiene Amend #20b Per FH G865 3/27/17/20 of Death Reg. No. 2. Date of Deat 19 Day 1. Decedent's Name (First, Middle, Last) 3. Time of Reath Month Year Physician Mon 2007 Even so /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 214-22-2506 Days 1**™** M 2□ F Months Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County fshow ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, t<u>he Medical Examiner must be notified at</u> 1 **27**es 2 □ No MD **Funeral Director** 1+imore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 If Yes, Give Year or Dates 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Megnet, and Injury or other traumatic event, the Megnet. mentary/Secondary (0-12) College (1-4or 5+) Station Manager MOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stevenson anie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SUM-OND 208. Place of Disposition (Name of WOOD ALANT) 20a. Method of Disposition 20c. Location -Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 14/07 21. Signature of Funeral Service Licensee augh 0ock Pcl. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatr Prostate **Physician** cancer years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Der tension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 24a. Was an autopsy performed? Yes 2 100 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural 1 🗌 Yes 2 No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Manyland 1000 Eager 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🥍 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 23, 2007 Maurice Kenneth Sales рм 8:55 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/08/1926 Birthplace (State or Foreign Country) Months Days Hours Min. 1**1** M 2 □ F 423-24-0422 80 ALUsual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits MD Prince George's Fort Washington 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13408 Reid Circle 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1XX Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: **Black** Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant 12 Justice Department 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leon Sales Mary Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13408 Reid Circle, Fort Washington, MD 20744 19a. Informant's Name/Relationship_(Type. Print) Renee Senegal / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State March31, 2007 Huntsville, AL 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Charles L. . Name and Address of Facility Stevens Funeral Home Inc. Marshall East Fort Avenue, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Autemy oconsia disease or condition resulting in death) as a consequence of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b Time of 28d. Describe how injury occurred (Month, Day 1 Natural 2 Accident 5 ☐ Pending investigation

Physician /Medical Examiner

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requires that the death certificate be executed

Box 68760,

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Division or Vital Records,

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29a. Certifier

4 Homicide

(Check only one)

To the Hosp...
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To the Funeral Director: After a contract of the funeral Director. Medical

State Registrar 29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

Livingion Road Fort WASHINAM

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 ANNER 11701 illain

MI 31. Date filed (Month, Day, Year) 32. Degistrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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SOUTHCOMB, EATER

		For State Of Mary - State Registrar		artment of H rtificate of L			Reg. No.	1111	09605
Physicia	an	1. Decedent's Name (First, Middle, Last) Richard W. Seyda, Sr.				2. Date of Dea Month	Day	Year	3. Time of Death
/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	loch:tal	4b. City, Town, or	Location of Death	Trace		nty of Death	10-100
Funeral Director		5. Social Security Number 219-12-7091 1 M 2□ F 7. Age (III	n yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April 9			olace (State or Foreign oldry) ylvania
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be filed within 72 hours after death with the Maryland tall Hygiene. tal Hygiene. d other than "natural", or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified.	by Funeral	11. Marital Status 1 Never Married ZM Married 3 Widowed 4 Divorced 12. Was Decedent Eve Amed Forces? 1 Myes 2 No If Yes, Give Year or Dates Nat		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)	1	lace - Americ llack, White, cify Whit e	etc.
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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Monee.	To	19a. Informant's Name/Relationship (Type, Print) Lillian Seyda- Spouse		ng Address (Street a					Code)
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Othe Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transition.	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cond	Sis	J					
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841		30. Name and address of person who completed cause of deat	th (Item 23a) (Type,	al- Ca	iave Dr	ive B	altim	ione	Md 21237
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's	Signature.	donelle					

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the Hospital or Attending

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/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 238 any Injury or other traumatic event, the Medical Examiner must gonee.

Physician

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Baltimore, Maryland 21215-0036

Director

Completed by Funeral

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(Check only one) 29b. Signature and

after death. within 24 hours a To the Funeral L

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State Registrar erson who completed cause of death (Item 23a) (Type, Print)

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

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			State of Maryland 1_ state Amend #19a, perFH, C865, 3/27/07 T	/Depa	rtment of H	lealth and N Death	lental Hygi	iene	7 00007
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_	Funeral	3 MP	JEWISH CONVALESCENT CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	BALTIM If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	BALTI 9. Bit	thplace (State or Foreign
	Director		217-01-4747 1XM 2□F 88	Yrs.	Months Days	Hours Min.	09/11/19	918	MD
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5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Wy es 2 No if Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba □ Yes 2ሺ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
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aryland	should be and Mental s marked o umatic eve	To	MORRIS		DDY	YETTA			BAUM
ā Z	C1 .0 - C							City or Town, State, DRE, MD 21	•
altimore,			20a. Method of Disposition 20b. Plac	ce of Dispos	sition (Name of natory or other place	ce)	Date 2	20c. Location - City o	r Town, State
Ē	Pages tment of I tant: If its ijury or o		The popular and the control of the c	NGTON D CONG	CHIZUK	03/2	5/2007 E	BALTIMORE,	MD
Ba	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Licensee			. 50		SON & BROS	
Ü			23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause of each line.					PIKESVILLE st,	MD 21208 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PINZ	1 1	RCTION	/	IM	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequent	nce of):				55.5	76
	2%	ner	Sequentially list conditions, if any, leading to immediate cause. First I Indexing.	ice of).					
	ecuted and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C						
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O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 🔲	Ectopic pregnancy Other <i>(specify)</i>			23d. Date of de Month	elivery Day Year
ď.	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
ecords,	w require been sig should b		VIAGGS MANNS		·		1 □ Ye	s 2 No 3 □ P	robably 4 □Unknown
Vital Rec	40 D	Completed					24a. Was an autopsy perform	prior to	
	siclan: The certificate rector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Yoo Hospital: 1 ☐ Inpatient 2 ☐ ER		OTI DOA Othe		h (Check only one		
0	or Attending Physician: ifter death. Director: After this certific in by the funeral director.	\vdash	27. Manner of Death 28a. Date of Injury 28	R/Outpatient 8b. Time of Injury	3 DOA 28c. Injun		me 5 ☐ Resider 28d. Describe how	nce 6 Other (Spe w injury occurred	ecify)
SIO	tendin eath. tor: Af the fur	catio	2 Accident investigation		M 1□	Yes 2 No			
DIVISION	l or At after d Direc	Certification:	4 Homicide determined 28e. Place of injury - At home building, etc. (Specify)	3, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	lural Route Number,
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a ate and place, and du	s stated. le to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier)	29c. License	e number		d. Date signed (Mon	
)	~		My omna, MI		1	(S/80		1HRCH 8	4, 2007
0	2 1		30. Name and address of person who completed cause of death (Item 23) 31. Date filed (Month, Day, Year) 32. Segistrar's Signature	011	Print) /+ H.	Ane.	Bona	MARCH J	200
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 2 7 2007 32. egistrar's Signatur	1 Apr	Sel.	,			

_			1 - For Amend #10e, peri		27/07 1	T Depa	rtment of l tificate of	Health and N Death	Mental Hy	rgiene Reg. No. 2	007	09638	
-	Physici /Medic		Decedent's Name (First, Middle, Las RUTH	st)		SH	IAPIRO		2. Date of De Month March	Day 24, 200	O7	3. Time of Death 12:30pm M	
	Examir Funeral Director		4a. Fecility Name (If not institution, give Greater Baltimon 5. Social Security Number 213-30-3866	re Medical	Cent (In yrs. Ias 78		4b. City, Town, TOWSON If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bi (Month, Di 04/01/	Balt	nty of Death Limore 9. Birth		
•	pu .	tor	Usual Residence of Decedent 10a. State 10b. County MD BALTIMO	DRE		Town or Loc			04/01/	1920	10d. Inside City Limits 1 □ Yes 2 □ No		
	th with the M 23a or 28a-f	ai Director	10e. Street and Number 1 GRISTMILL COURT	COURT #60			10f. Zip Code 21208	3		10g. Citizen	of What Cou	ntry?	
) 0036	ours after death with the Maryla ral', or items 23a or 28a-f sho: Examirer mast be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Y Year or Dates:				Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No Rican, etc.)	ο- 14. F Ε <i>Sp</i> e	lace - Ameri llack, White, cify: WH]	etc.	
21215-0	ad within 72 h /giene. er then "natu f, ihe Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5- 2	+)	16a. Deced (Give I life. D	ent's Usual Dccu and of work done O NOT use retire	pation during most of work id)	ung	16b. Kind of	Business/In	,	
Shapico Ralimore, Maryland 21	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than eny injury or other traumatic event, the Magnee.	To Be (17. Father's Name (First, Middle, Last) HARRY			FE	LSER	18. Mother's Nam	e (First, Middle		ame)	CHELSON	
e, Mar	t and 2 sh fealth and fm 27 is m ther traum		19a. Informant's Name/Relationship (7 CLAIRE HOFFMAN /	•	20b Blac	1 WES		WAY - LUT		_E, MD	21093		
Sh C	permit. Pages Department of timportant: If its eny injury or of		20a. Method of Disposition 1)	cen	IMORE	Atory or other pla	03/26	5/2007	20c. Locatio	RSTOWI	N, MD	
Ba	permi Depa impo eny ii		23a. Part1. Enter the disease, or comp		the death	8		STERSTOWN		PIKESV	BROS.	MD 21208 Approximate	
68760,	Physician /Medical Examiner building the prival-transit	edicai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a d.	e. Conseque conseque	nce of):	CU	uf a	næ	×	5	Interval Between Driset and Death	
Вох	it the deeth certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the g □ Unknown	2 Fetal de	eath 3 1	Ectopic pregnanc Other (specify)	у			Date of delive Month	ery Day Year	
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al Reco	iicien: The law ra certificete hes be rector, page 2 shu	e Completed	Of War and the state of the sta						1 ☐ Yes	psy prmed? 22 No	death?	psy findings available mpletion of cause of	
Division of Vital Records, P.O.	or Attending Physite death. Iter death. Irector: After this n by the funeral di	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident investigation 3 Suicide 6 Could not be determined		Year) 28	VOutpatient Bb. Time of Injury a, farm, stre	28c. Injui Wo.	Yes 2 □No	me 5 Resi	dence 6 D how injury occ	urred	y) al Route Number,	
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	To the within 2	W	29b. Signature and title of certifier	Caou	oli	ND	29c. Licens	se number (,	29d. Date sign	ned (Month,	pay Year)	
	10		30. Name and address of person, who c				rint) N CH	ARLES BACTING	STRE	FLO	213	204	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 7	32. Registrat	r's Signatur IASS .	H. M	bark						

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any liptur or rother than "natural".

Baltimore, Maryland 21215-0036

Physici /Medio Examir

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Reg

		1 - State State Registrar	of Maryland /		artment <i>rtificate</i>			nd Me	-	_	000	7 00	c 0 /
	-1	Registrar 1. Decedent's Name (First, Middle, Last)			imodic		- Catri	2	2. Date of De	Reg. No.	- 200	3. Time of I	Death
sicia		ANNA SHER	MAN						Month MARCH	(Z		2	
edic min		4a. Facility Name (If not institution, give street and no			4b. City, To	own, or	Location of				County of Dea		•
		NORTHWEST HOSPI	TAL		PA	MD1	ALLS"	TOU	いと		BALTIMO	RE	
ral tor		5. Social Security Number 6. Sex 1 M 2 F	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours		B. Date of Bir (Month, Da 08/30/		9. Bi _l	thplace (State or ountry) RUSSIA	Foreign
		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation							10d. Inside City	/ Limits
3	o	MD N/A	BALTI	MORF								1 _v Yes	
	Director	10e. Street and Number	D/(E11)	IIOIL	10f. Zip C	Code			10g. Citizen of What Country?				
		3601 FORDS LANE #711			2121	5			U.S.A.				
	Funeral		cedent Ever in U.S.	13. \		nt of His	spanic Origir	n? (Speci	ify Yes or No		14. Race - Am-		
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	ed by	3 ☐ Widowed 4 ☐ Divorced Year or 15. Decedent's Education		Sa Dagar	dent's Usual	Occupa	tion			16h Vi			
	plet	(Specify only highest grade completed	"	(Give	kind of work DO NOT use	done d	urina most a	of working	7	16b. Kind of Business/Industry			
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	To.	NAUM		DUI	<u> </u>		DOBA					ROS	SEN
		19a. Informant's Name/Relationship (Type. Print)	l l		-						or Town, State,	, ,	
		ALEXANDER SHERMAN / HUSE 20a. Method of Disposition			sition (Name		E #/11	L – E			MD 212		
5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State ceme	etery, cren	natory or oth	er place	· !				•		
o o		21. Signature of Funeral Service Licensee	BALIII	MORE 22	HEBRE . Name and	M_C(Addres	ONG ±03 s of Facility				STERSTO BROS		
once		Maul Ce		8	39 0 0 R	FIS	TERSTO				a BRUS ESVILLE	•	208
		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. D									Approximate Interval Betw	
an		Immediate Cause (Final disease or condition	THICILLIA								UREUS-	Onset and D	eath
eal er		resulting in death)	(or as a consequence					1					
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	by F	Part II. Other significant conditions contributing to	death but not resulting	g in the ur	nderlying cau	ise give	n in Part I.					o the cause of de	
	ted								1 🗆	Yes 2[∐No 3∐P	robably 4,2⊞Uı	nknown
	Completed by Physician/Me								24a. Was auto perfo		death?	utopsy findings a completion of cars	vailable use of
	Be	25. Was case referred to medical examiner?					26. Place o	f Death (Check only o				
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	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place	e of injury - At home,	farm, stre			′es 2 No	-	f Location (Stroot an	nd Number or F	ural Route Numb	107
	erti	4 ☐ Homicide determined built	ding, etc. (Specify)						City or To	wn, State)	arar riodeo ridiria	
	Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the 2 Medical Examiner: On the and ma	ne best of my knowled basis of examination nner stated.	lge, death and/or in	occurred at vestigation, i	t the tim	e, date and pinion, death	place, ar	nd due to the d at the time,	cause(s) date and) and manner a d place, and du	s stated. e to the cause(s)	
	Me	29b. Signature and title of certifier					number	-		29d. Dat	te signed (Mon	th, Day, Year)	
) le	7,00				435			MAI	nch 2	3 200	7
		30. Name and address of person who completed can Notottwest to spita								10	~ () 1 . A \	IIS am	5.5
Stai	te	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	لاب) .		لا)، ص	105(- DAG	-031	0 600	1 D C11	۵
istra		MAR 2 7 2007 See	Registrar's Signature		P								

			State of Maryland / Dep. State of Maryland / Dep. 1- State	artment of Healt	th and Me	ntal Hygier	ne				
				Tillicale of Dea		Reg. I	No.2007	3. Time of Death			
	Physicia	an	1. Decedent's Name (First, Middle, Last)			Month I	Day Year				
	/Medic		Albert Nelson Slinkman	I di Cita Tanan ant anni		March 20		6:00 A M			
3	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Local			4c. County of Death				
			3009 Evergreen Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimo:		. Date of Birth	N/A	place (State or Foreign			
	Funeral Director		220-03- 1970 XM 2 F 93 Yrs.	Months Days Hou	urs Min.	(Month, Day, Ye.	1913 Mary	ntry)			
			Usual Residence of Decedent			Julie 23,	1913 Mary	Tallu			
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits			
	Mar a-f st	혅	Maryland Baltimore Parkvill	.e				1 □Yes 21X No			
	n the	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Cou	ntry?			
	th will		8800 Old Harford Road	21234		Un	nited Stat	es			
	ems er m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specif exican, Puerto Ric	ty Yes or No- can, etc.)	14. Race - Ameri Black, White,				
õ	or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑ No Spe	ecify:		Specify: Whi	te			
0030	be fled within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural" or items 23a or 28a-f show dother than "matural" or items event, the Medical Examiner must be notified at	d by	3₺ Widowed 4 Divorced Year or Dates:	dent's Usuel Occupation		16h	. Kind of Business/Ir	ductor			
ņ	"nat	Completed	(Specify only highest grade completed) (Give	e kind of work done during DO NOT use retired)	most of working	100	. Killa of Basilless/if	dustry			
7	withir ene. than he M	Ę.	Elementary/Secondary (0-12) College (1-4or 5+) 2 Sale			I	ood Manuf	acturer			
N 0	e filed within 72 h al Hygiene. I other than "nati vent, the Medica	ပ္	17. Father's Name (First, Middle, Last)		Mother's Name (I	First, Middle, Maid		acturer			
and	2 should be f n and Mental H Is marked of raumatic eve	To Be	Albert C. Slinkman	Ed	lith Br	own					
<u></u>	shoul nd M marl	-	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ing Address (Street and N	lumber or Rural I	Route Number, Ci	ty or Town, State, Zi	code)			
Ma	nd 2 alth a 27 Is r trau		Rose Mettle 619	Tanglewood D	Orive Sy	kesville	, MD 2178	4			
ē,	s 1 a of Hez Item othe		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	Dat	e 20c	. Location - City or T	own, State			
Ē	Page tent c nt: If iry or		1 K Bunal 2 ICremation 3 IRemoval from State	emorial Park	March	24, 2007	Sykesvil	le, MD			
аппо	permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 Is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Licensee 2	2. Name and Address of F	FacilitLorin	g Byers	Funeral D	irectors,In			
מ	9 9 E E E		Joseph J Kellner M00333 8	728 Liberty	Rd. Ran	dallstow	n, MD 211	33–4784			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		ch as cardiac or i	respiratory arrest,		Approximate Interval Between			
q. I	Physician		immediate Cause (Final disease or condition a Coronary Orter	disense				Onset and Death			
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	p t	iner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.								
	and -trans	Examine	that initiated events resulting in death) Last Due to (or as a consequence of):								
8/60,	the death certificate be executed y the attending physician and iched for use as the burial-transit	al E	But to (or as a contesquence or).								
ģ	phys the	dical	d								
×	death certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy				23d. Date of deliv	erv			
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7	w requires that the do been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in F	Part I.	23e. Did tobaco	co use contribute to	the cause of death?			
	quires n sign	d by	His Ronal tentul			1 ☐ Yes	2☑No 3□Pro	bably 4 □Unknown			
Hecords	law recast bee	Completed				24a. Was an	24b. Were aut	opsy findings available			
	sician: The law certificate has b irector, page 2 s	mo				autopsy performed 1 Yes 2. ✓	death?	ompletion of cause of 2 □ No			
VITAI	an:] tiffical tor, pa	Be C	25. Was case referred to medical	26. I	Place of Death (1	NO TETES	2010			
>	ysici is cer direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4	Nursing Home	5 Residence	e 6 □Other (Spec	fy)			
יס ר	ig Ph ter th neral	n: T	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 28b. Time of (Month, Day Year) 1 Natural 1 □ Pending (Month, Day Year)		1	d. Describe how i					
0	ath. or: Af	atio	2 Accident investigation	M 1 ☐ Yes	2□No						
UIVISION	ir Atta ter de irecta irecta i by tl	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28	f. Location (Stree City or Town, S	t and Number or Rui tate)	al Route Number,			
2	ital o rs aft ral Di lled ir	Cer									
	Hosp 4 hou Fune ely fil	ical	29a. Certifier (Check only (
	To the Hospital or Attending Physician: white 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director,	Medical	one) and manner stated. 29b. Signature and title of certifler	29c. License num	nber	294	Date signed (Month	Dav. Year)			
	N N N		255. Signature and the stronger				3/20/	7			
	9		SO No and address of a second	Print)	-1-1/		110-10				
5	2 '		30. Name and address of person who completed cause of death (Item 23a) (Type 23i4 E. Joyna Rd Butto	MONE MC	39297	34					
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature								
	Registr		110 Q 7 2007 House M. Ba	aste s							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 Per Phy G866 4/16/07 JH

Certificate of Death

Reg. No. &19a 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dav Year Physician 8:10 PM Phillip Scott 2007 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 638 South Oldham Street Baltimore n/a 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours ¥□M 2□F 213-82-7140 44 Sept19,1962 Maryland Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MYYes 2 □ No Directo Md. n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 638 Oldham Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Self-employed Home Improvements marked other Injury or other traumatic event, PEATHER'S Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 9 Department of Health and Mental mportant: If item 27 Is marked o hiliip Garland Scott Betty Doris Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 638 Oldham St. Baltimore, Md. 21224
Date | 20c. Location - City or Town, State Melissa M. Scott / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-26-07 Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Kaczorowski Funeral Home, PA tendor 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic **Physician** 2 MONTH Canta /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an s certificate has birector, page 2 s autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient မ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation the Funerall Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 19714 March 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael M.D. J. Purtell 4940 Eastern Ave. Baltimore, Md. 21224

Registrar

State

31. Date filed (Month, Day, Year)

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ORIGINAL

32 Registrar's Signature

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	Ni.	Registrar 1. Decedent's Name (First, Middle, Last)		Cei	lineale of L		2.	Date of Dea	ith		3. Time of Death
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Exam		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, or	4	1	1		ty of Death	
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Funera Directo		5. Social Security Number 3. Sex	7. Age (In yrs. las	Yrs.	Months Days	Hours	Min.	(Month, Day	, Year) 1929	9. Birth Cou	place (State or Foreign intry) MD
pu ,		Usual Residence of Decedent	100 City	Town or Lo	antion			, -,,			10d. Inside City Limits
faryla shov	Į.	10a. State 10b. County	Toc. City,	TOWITOT LO		ltimore					122 Yes 2 No
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r deal	Funeral	A Particular States	Vas Decedent Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Orig n, Mexican,	in? (Specify , Puerto Ric	Yes or No- an, etc.)		ace - Amen	ican Indian, , etc.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Fi	_ X	∰Yes 2 ဩ No Yes, Give ′ear or Dates:		1⊡Yes 2.2MiNo	Specify:			Spec	ifX: Africa	an American
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d 21 filed wi Hygier sher th	ပ္ပ	17. Father's Name (First, Middle, Last)			shipper	18 Mother	r'e Nama <i>(F</i>	iret Middle	Sparrow Maiden Surna		Ship Yard
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laryla 2 should and Men is marke	P	19a, Informant's Name/Relationship (Type, F		19b. Mailir	ng Address (Street a	and Number				n, State, Zi	ip Code)
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altimore, rmit. Pages 1 ar partment of Hea portant: If item y injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	1 001	ce of Dispo metery, crer	sition (Name of natory or other place	e)	Date	'	20c. Location	n - City or T	Town, State
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Balti permit. Departr Importa any inju	ouce	21. Signature of Funeral Service Licensee	na O O	22	638 North		Wyll		al Home		1 21217
		23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one or	us that caused the death.	Do not ent							Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition	Intracrani		leed						Onset and Death
/Medica		resulting in death)	Due to (or as a conseque								
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Division or Vital Records, P.O. Box 6 or Attending Physician: The law requires that the death certificater death. Director: After this certificate has been signed by the attending I in by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	I□Live birth 2□Fetal d I□Pregnant at time of dea	leath 3	Ectopic pregnancy Other (specify)			-)	Month	Day Year
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r VI ysicia iis cer direct	To Be	examiner? 1 Yes 2 No Hosp	ital: 1 ☐ Inpatient 2 🔀 E	R/Outpatier	nt 3 DOA Othe	er:			lence 6 🗆 C	ther (Spec	sify)
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Div after Direct	Certification:	4 Homicide determined ≥	building, etc. (Specify)	10, 141111, 94	oot, idotory, ombo		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Division or Vital Reform to the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page			n: To the best of my knowl On the basis of examination								
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10		DO Nove and address of person who comple	ated source of dooth (Itom (23a) (Tyne	Drint\						
*		Sabrina Nettie Kra		th G	reene Str	reet	BaHi	more	, Mari	Mana	1 21201
	State	31. Date filed (Month, Day, Year) MAR 2 7 2007	32. Registrar's Signatu	ire	ii. 1					J	
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0061 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 20, 2007 **EULA** VIRGINIA SIMMONS March 5:04 P M "/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mythe 47, 4926 9. Birthplace (State or Foreign Aกาศาสตรร, Virginia 7. Age (In yrs, last birthday) Social Security Number **Funeral** 1□M 2XF 227-28-8942 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Mt. Airy Maryland Carroll 1 ☐ Yes 2 No Director 10g. Citizen of What Gognty? 10e. Street and Number 10f. Zip Code 21771 4308 Cedar Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 White Specify: \$ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Private Duty Nurse 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Healthcare Elementary/Secondary (0-12) College (1-4or 5+) other than 18. Mother's Name (First, Middle, Maiden Surname) Baby Belle Lawless 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file trainent of Health and Mental Hitant: If item 27 Is marked oth Be Lemon Adcock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Bural Route Number City of Toyon, State, Zip Code) 402 N. Main Street Mount Airy, Maryland 21771 Daughter permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trau Ms. Ann Tiebocsh Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Elkridge, Maryland 03/24/07 Meadowridge Memorial Park, Inc. Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Home, P.A. Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebrovasular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending F after death. 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MO 040307

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CNOB MUD Registrar's Signature 31. Date filed (Month, Day, Year) MAR 2 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physicia I Exami	an/	Decedent's Name (First, Middle,Last)	Smith			2. Date of Death Month [March 22, 2		3. Time of Death 1531 hrs		
			4a. Facility Name (if not institution, give street 4403 Rena Rd #203	and number)	1 1	4b. City, Town, or Location of Death Forestville 4c. County of Death Prince George's					
	uneral irector		5. Social Security Number 318-64-3894 6. Sex	7. Age (In yrs. last bi		ear If Under 24Hrs lays Hours Min	-	(MM/DD/YYYY) 9. Birt Foreig , 1964 Col			
-	ith the Maryland 23a or 28a-f show any notified at once.	j	Usual Residence of Decedent 10a. State								
;		Director	10e. Street and Number 8996 NC Highway 3	9 N	10f. Zip Code 2753		_	10g. Citizen of What Country? USA			
	or items	Funeral	1 Never Married 2 Married Ar	as Decedent Ever in U.S. med Forces? Yes 2 No	13. Was Decedent of If Yes, specify Cut	oan, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,		
36	Id be filed within 72 hours after death with the Maryland Aental Hygiene. arked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12th 16b. K Sheet-metal Fabricator						Company		
21215-0036	ould be filed within I Mental Hygiene. I marked other this ic event, the Medi	Be Con	17. Father's Name (First, Middle, Last) Vincent Giuffree				First, Middle, Ma	aiden Surname)			
D 21	e na de	2	19a. Informant's Name/Relationship (Type, Pri Carolyn Eaton /fi	ance	9b. Mailing Address (St 8996 NC F						
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П	ysician Vegical aminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Multip	le Gunshot Wounds (or as a consequence of):	not enter the mode or dyn	ng, such as cardiac o	or respiratory arros	i, shook, or hour	Between Onset and Death		
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Box 68760	leath certificate be ex e attending physician for use as the burial	Physician/Me									
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Rec	certificate ector, page		25. Was case referred to medical		26.P	ace of Death (Check	1 Yes 2	No 1 ✓ Ye	es 2 No		
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Division	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be	Be. Place of Injury - At home, Specify) Multi-Family A		ce building, etc.		reet and Number or Ru ate) #203, Forestville, M	nral Route Number, City		
	To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying Physician: To one) 2 Medical Examiner: On the	the best of my knowledge, or basis of examination and/o	death occurred at the time or investigation, in my opio	e, date and place, an nion, death occurred	d due to the cause at the time, date a	(s) and manner as stated and place, and due to the	ed. le cause(s)		
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	4		30. Name and address of person who complete		a)		1201				
		tate	24 2 4 5 4 4 4 5 4 4	Medical Examiner 2. Registrar's Signature	111 Penn Street, E		1201				

24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was ca			1	For State Registrar	State of Ma	aryland		rtment tificate			nd M		giene Reg. No.	200	7	09645
Activities Continue Continu		Dhysisis		Decedent's Name (First, Middle, Last)								Month	Day			
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Emil Thomsen Sanna Brickman 19a. Indoman's Namer Relationship (Type, Print) 19b. Maling Address (Sheel and Number; City or Town, State, Zip Code) Melinda A. Ceise (Daughter) 20a. Memory of the state of the st	2						Mac	шшѕ	L	18. Mothe	r's Name	(First, Middle.			Huu	SLLY
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29b. Signature and title of certifier MD 29c. License number Do662634 29d. Date signed (Month, Day, Year) Do662634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATIEEN A. AWAN . MD 10802 HICKCRY RIDGE RUAD CCLUMSIA MD 21044	<u></u>	Hospita 24 hours Funerel etely filled		(Check only 2 Medical Examin	er: On the basis of and manner si	of examination tated.	on and/or in	vestigation	, in my o	pinion, dea	th occur	red at the time,	date an	d place, and	due to	the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATEEN A. AWAN. MD 10802 HICKORY RIDGE RUAD COLUMBIA MD 21044		To the vithin Fo the complex	Æ	29b. Signature and title of certifier	4.4	Δ.		29	c. Licens	e number			29d. Da	te signed (N	fonth, l	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATIEN A. AWAN . MD 10802 HICKORY RIDGE ROAD COLUMBIA MD 21044		/\		A Water	/VI_	0			Doc	626	34		03/	24/07	CM	ARCH
The state of the s		Dx.		30. Name and address of person who com MA TIEN A. A	mpleted cause of war. Me	death (Item :	23a) (Type,	Print)	cry	2106	E A	LAD CC	LUM	SIA M	0 2	21044
State 31. Date filed (Month, Day, Year) 32. Highstrar's Signature Registrar MAR 2. 7 2007				31. Date filed (Month, Day, Year)	32. Ha gist	trar's Signatu	Ire J. Ad	make	,							

Christopher Alle		cker Si 1- For State Registrar	tate of Maryland		artment of rtificate of		nd Mer	ntal Hy		eg. No. 20	107	0964
Physici	an/	Decedent's Name (First, Midd	lle,Last)						2. Date of Dea Month		3	. Time of Death
Medical Exam	iner	Christopher Al							March 22,	, 2007		1550 hrs
		4a. Facility Name (if not institution	on, give street and number	er)	1	4b. City, Town, Sparrows		of Death		4c. County of Baltimore		h.
		2505 Maple Road 5. Social Security Number	6. Sex 7. /	Ago (la uso	last histhday	If Under 1 Y		der 24Hrs.	le Data of Bir	th(MM/DD/YYYY)		
Funeral Director		212–02–3316		Age (III yrs.	last birthday)	Months D	ays Hour		1		Foreign	
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any	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion					11	Od. Inside City Limits
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th the M. 23a or 2. notified	Director	2505 Maple Road	đ			2	1219			USA		
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after a	by F	3 Widowed 4 Div	vorced If Yes, Give Year or Dates:		1	Yes 2X	No specify	<i>/</i> :		Specify:	Whit	e
hours afte "natural", Examiner	룺	15. Decedent's Education (Spe	ecify only highest grade c			t's Usual Occu ost of working I				16b. Kind of Busi	ness/Ind	ustry
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e, MD 21215-0036 I and 2 should be filed within 72 Health and Mental Hygiene iten 27 is marked other than " r traumatic event, the Medical.	ı	20a. Method of Disposition		20b.	Place of Dispos crematory or ot	ition (Name of	cemetery,		Date	20c. Location - 0	City or To	wn, State
S Je H		1 XBurial 2 Crematio 4 Donation 5 Other S		State St.	Stanisla	us Cemete	ery	20	ch 26,	Baltimo	ro	Maryland
Baltimore, permit Pages I ar Department of Hee Important: If ite	ł	4 Donation 5 Other S 21. Signature of Funeral Service		01	22 N	lame and Addr	ess of Facili	1 -		Dundalk,		
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Physician		23a Part I. Enter the disease, or failure. List only one cause	r complications that cause	ed the death	. Do not enter ti	ne mode of dyir	ng, such as	cardiac or	respiratory arr	est, shock, or hear	t	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease	TT .	d alcoh	nol intox	ication						Death
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876 tifica ing ph as the	<u> </u>	23b. Was decedent pregnant in t past 12 months?				tal death	3 Ectop	oic pregnan	псу	Month	Day	Year
Box 68760, e death certificate be the attending physic ed for use as the burned for use	sician/M		known	at time of de	eath 5 Ot	her (Specify)						
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f Vi Physi er this ral diu	욘	1 Yes 2 No 27. Manner of Death	28a. Date of I	niury	ER/Outpatient		niurv at Wo		Home 5	Residence 6 how injury occurred	-	scene
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Divisior Hospital or Attenc 24 hours after death : Funeral Director: etely filled in by the		29a. Certifier 1 Cortifuing 5	Physician: To the best of			rred at the time	date and p	olace, and				
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical		aminer: On the basis of e	xamination								
5 iv 5	Me	29b. Signature and title of certification	and manner state ier	ou .		29c. Lice	ense numbe	er		29d Date signer	d (Month	n, Day, Year)
		lat all	AA			0.0	C.M.E.			March 23, 2	007	
		30. Name and address of person	n who completed cause of	of death (Iter	n 23a)					1		
		Zabiullah Ali, M.D.	Assistant Medical	Examine	r 111 Per	n Street, B	altimore,	MD 212	201			
	tate	12 h m m	No.	trar's Signat	ture La	well .						
Regis	trar	MAR 2 7	7 2007	7	- 17							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. FoAmend #20a-c Per FH G865 3/27/0 per rement of Health and Mental Hygiene Registrar Certificate of Death Red. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marchin 22, 2007 Physician Anne M. Vach 7:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | June | 25 , 1920 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 216-14-0072 1 □ M 2 🗙 F 86 Baltimore, MD Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8915 Satyr Hill Rd. 21234 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: White þ 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) 12 College (1-4or 5+) Liquor Board Executive Secretary ulth and Mental Hvr 17. Father's Name (First, Middle, Last)
Clarence B. McComas 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Klug 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tanya Lee James- Daughter permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 2711 Sarah Lane Baltimore, MD 21234 Date 20a. Method of Disposition Forest Hillow MD ate ²Evarist Transier ATth Chapel The Surial 2000 remation 3 Removal from State Dulaney 3/25/2007 Timonium, MD 4 Donation 5 Dother (Specify) 1 Cardens 22 Name and Address Evansily Funeral Chapel & Cremation Services Parkville 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licenses 23a. Pan1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock. In heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** west /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ifjury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2☐Ño 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 05016 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 Yes 2 No Hospital or Attend 24 hours after death. Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral C completely filled i I 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

 \mathcal{O}_i

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of teath (Item 23a) (Type, Print)

5mc

32. Registrar's Signature

DHMH 17 Rev 1/2001

the

33,300

29c. License number

7.25205

6701 N-Churles St. Balto md 2120>

29d. Date signed (Month, Day, Year)

Mrch 22, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Mar Registrar		Department o Certificate	of Health and	Mental Hy	21	107	09648
	-		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate	oi Dealli	2. Date of D	Reg. No. 🛴 🔾	101	3. Time of Death
	Physic		Anthony Joseph Varella				Month 3	Day	Year	
	/Medi Examii		4a. Facility Name (If not institution, give street and number)		4b. City, Tov	vn, or Location of Deat			2007 y of Death	5:10 PM
	Funeral Director		218-26-0470 ¹ ☑M 2□F	(In yrs. last birt		SedAle ear If Under 24 Hrs ays Hours Min.	8. Date of Bi	Day, Year)	9. Birthp Coun	AONE place (State or Foreign ryland
	and *		Usual Residence of Decedent 10a. State 10b. County 1	10c. City, Town	or Location					
	Maryla F sho ed at	ō							'	10d. Inside City Limits 11X□ Yes 2 □ No
	the 1 28a- notifi	rect	Maryland N/A 10e. Street and Number	Balt	imore 10f. Zip Cod	de .		10g. Citizen of	What Cour	
ļ)	3a or	O E	6409 Danville Avenue							
	deat ems	Funeral Director	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S.		1224 of Hispanic Origin? (S Cuban, Mexican, Puer	pecify Yes or N	lo- 14. Ra	d Sta	an Indian,
7 7 36	hours after death with the Maryland tural", or Items 23a or 28a-1 show al Examiner must be notifiled at	Y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1	1 ☐ Yes 2X		to Hican, etc.)		ck, White,	etc.
200	hours tural'	d by	3 Wildowed 4 Divorced Year or Dates:					Speci	Wh	ite
VARe11	iin 72 n "na fedic	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Oc (Give kind of work de life. DO NOT use re	ocupation one during most of wo etired)	rking	16b. Kind of E	usiness/inc	dustry
122	d with giene rr tha	E O	Elementary/Secondary (0-12) College (1-4or 5+) 9 vears		bestos Wor			Asbest	os In	stallation
P P	al Hy l othe	Be	17. Father's Name (First, Middle, Last)		oco cos wor		me (First, Middle	e, Maiden Surna		
<u>ya</u>	Duid b Ment arked atic e	10	Nicholas Varella			Angeli	na Lavio	ola		
√ / Maryland	12 sh h and r is m raum		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Str	reet and Number or R	ural Route Numb	ber, City or Town	, State, Zip	Code)
	1 and Health em 2		Molly L. Varella (Wife) 20a. Method of Disposition	64	409 Danvil	le Avenue	Baltim	nore, Ma	rylan	d 21224
1 5m	ages ent of t: If it y or o		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemeter	y, crematory or other	place)	Date	20c. Location	· City or To	wn, State
$A_{N}Th_{0}$ Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service (Icensee	Dulane	ey Valley 22. Name and Ac	Mem. 3/26	5/2007	Timoni	um, Ma	aryland
B	Depar Impor any tr		100 mg		Duda-Ruo	ck Funeral se Avenue	Home of	Dundal	k, In	C. 1222
			 Part1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line. 	e death. Do n	ot enter the mode of	dying, such as cardia	or respiratory a	arrest,	1114 2	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. M I							Onset and Death
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	signed to		Part II. Other significant conditions contributing to death but n	ot resulting in	the underlying cause	given in Part I.	23e. Did t	tobacco use cont	ribute to the	e cause of death?
ord	w requir been si should	ted	Myelodysplastic				'汉	Yes 2□ No	3 ☐ Proba	ably 4 □Unknown
Zec	has b	Completed by					24a. Was	psy	Were autop	osy findings available opletion of cause of
a			OF Was ages referred to madical				perfo 1□ Yes	ormeg∠	death?	2 □ No
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Sior	vttendin death. ctor: Af y the fur	atio	1) Natural 5 □ Pending (Month, Day Yo 2 □ Accident investigation	ear) inj		Vork? ☐Yes 2☐No				
Division or Vital Records,	I or Attending Physician: after death. Director: After this certification by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (6	- At home, fam Specify)	n, street, factory, offic	ce	28f. Location (S City or Tow	Street and Numb wn, State)	er or Rural	Route Number,
	e Hospital 24 hours a e Funeral letely filled		29a. Certifier (Check only Americal Examiner: On the basis of ax	ny knowledge,	death occurred at the	e time, date and place	, and due to the	cause(s) and ma	ınner as sta	ated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examt manner stated 29b. Signature and title of certifier	l.		ny opinion, death occu				
	- s + 8				7) 7	10 115		3/2/0	i (ivionth, Di	ay, rear)
K	1	-	30. Name and address of person who completed cause of death	n (Item 23a) (T	ype, Print)	1776		7-70)		
			DR. MARTIN SKERIDAN 900	30 FRA	UKLIN S	guane DR	BAIT	more	MI	21237
Ü	Stat Registra	~	31. Date filed (Month, Day, Year) 32. Administrar's MAR 2 7 2007	Signature	Coasts 5	0	, ., ., .,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 22 Vecheck /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie <u>Anne Arundel</u> 8. Date of Birth (Month, Day, Year) March 3, 1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 208-16-3982 80 Director PA Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ortant: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Anne Arundel Director Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7400 Hawkins Drive 21076 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify. White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other transmitted. Elementary/Secondary (0-12) College (1-4or 5+) Senior Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dominik Vechik ٥ Annicia Vechik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Isabelle Vecheck/Wife 7400Hawkins Drive Hanover, MD 21076 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 26, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Meadowridge Memorial Elkridge, MD 4 ☐ Donation 5 ☐ 9ther (Specify) 21. Signature of ther 22. Name and Address of Facility Singleton Funeral Home, M01411 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o Examiner The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) signed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy page perform certificate 2∏ No 2[1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only on Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this Date of Injury 27. Manner of Death funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

State

one)

29b. Signature and title of certifier

com

Year

30. Name and address of

31. Date filed (Month, Day,

Registrar DHMH 17 Rev 1/2001

ORIGINAL

person who completed cause of death (Item 23a) (Type, Print)

32. Registra

29c. License number

29d. Date signed (Month, Day, Year)

21061,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician 200 1ancs /Medical 4a. Facility Name (If not institution, give street and number or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 212-30-5555 1 □ M 2 🔽 F Director 12/15/1932 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Event. 10c. City, Town or Location 10a. State 10d. Inside City Limits Baltimore 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1510 Mosher Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Completed by 3 Widowed 4 Divorced African American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert J. Smith Annie Smith ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen P. Bowman / Granddaughter 9019 Tarpleys; Baltimore, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 03/31/2007 Randallstown, Maryland 21. Signature of Funeral Service Licenses Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and I-transit The law requires that the death certificate be excuted Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnam 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 diknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforr certificate 1∐ Yes 2 1No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 DOA Certification: To this funeral 27. Manner Ceath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No I Director; / 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Medical

31. Date filed (Month, Day, MAR 2

29b. Signature and title of certifier

29a. Certifier

and manner stated

82. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

D003035

BON SECQUES HOS

Director

Funeral

Director

LEONARD

10b. County

5. Social Security Number

10e. Street and Number

10a. State

MD

216-36-4171

Usual Residence of Decedent

541 MAUDEN ST

E

MARYLAND

6. Sex

1 XM 2 □ F

WHITING

MEDICAL

CENTER

10c. City, Town or Location

BROOKLYN

7. Age (In yrs. last birthday)

67

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Months

10f. Zip Code

21225

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | if Under 24 Hrs.

Days

BALTIMORE

Hours

Reg. No.

Day

Year

4c. County of Death

10g. Citizen of What Country?

1939

USA

2007

NIA

14. Race - American Indian.

3. Time of Death

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits 1 ☐ Yes 2 No

4:19 PM

2. Date of Death

8. Date of Birth (Month, Day, Year)

APR. 25,

Month

MARCH

Carlise R Whye-Douglas

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State of Maryland /	Department of He	ealth and Mental	Hygiene

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,	Certificate of Death Registrar Reg. No.) (
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Carlise R. Whye - Douglas 2. Date of Death Month Day March 22, 2007 1342 hrs	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4do Chalet Court Apt. 2D 4do Chalet Court Apt. 2D	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Months Days Hours Min. 12 21 1962 Foreign Country)	
Maryland 28a-f show any 1 at once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1 1 2 Yes 2 N	
the Maryle 3a or 28a-footified at o	10e. Street and Number 4406 Chalet Court Apt 2D 10f. Zip Code 21206 10g. Citizen of What Country? USA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the McMcMal Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1	
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21215-0036 Juld be filed within 7 I Mental Hygiene. I marked other than ic event, the NV is a TO Be Comple	Joseph A. Pullum Joyce Whye	
e, MD 2121 and 2 should be fi Health and Mental item 27 is marked traumatic event.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2
	1 Removal from State Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: Moveland Nemovial D231 07 Baltimore, MD	_
	22 Name and Address of Facility	al
Physician Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Death Due to (or as a consequence of):	
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ted d ansit Examiner	Cisease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.	
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ion of Virtual of the function	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
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Division of Variety of Physical Physica	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 23, 2007	
10	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra	31. Date filed (Mark), Day Year) WAR 2 7 2007 Selection 14 Acad 5	
DHMH 17 Rev 1/2001	ORIGINAL	

		•	1 → For State Registrar	State of Ma	arylan		rtmen tificat			ind M		giene Reg. No.	07	09653
	Physicia	an	Decedent's Name (First, Middle, Last								Date of Dea Month	ath Day	Year	3. Time of Death
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	Funeral		5. Social Security Number 6. Se			ast birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birt	h Yaasi	9. Birth	place (State or Foreign
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	pu *		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							10d. Inside City Limits
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	within 72 hours after death with the Maryland sne. Then "naturel", or Items 23a or 28e-f ehow ha Medicul Examilian must be notified at	by Funeral Director	2704 Garnet Rd.				21	234				USA		
	deat	ner	11. Marital Status	12. Was Decedent 1 Armed Forces?	Ever in U.	S. 13. \	Was Deced	tent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. F	Race - Amer Black, White	
98	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑↑ If Yes, Give Year or Dates:	10	ĺ	1 🗆 Yes		Specify:			1	city.Whit	
Ö	hours turel'	q pe	3 Widowed 4 □ Divorced 15. Decedent's Ed			16a. Deced	dent's Usua	al Occupa	ation			16b. Kind o	f Business/l	ndustry
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land	ld be file ental Hy ked oth ic event	To Be (17. Father's Name (First, Middle, Last) Charles Mueller					i			(First, Middle, Luphy	Maiden Sun	ате)	
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23a or 28e-f show eny injury or other traumatic event, the Medical Examinat must be notified at anciety or other traumatic event, the Medical Examinat must be notified at anciety.		19a. Informant's Name/Relationship (T Kevin Dosher- Grandson				-				al Route Number a, FL 344		wn, State, Z	ip Code)
re,	s 1 ar		20a. Method of Disposition			lace of Dispo			e)		Date	20c. Locatio	on - City or 1	Town, State
Ë	Pege nent c int: If iry or		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Garr	iney vai Jens	-		3	/26/2	2	Timeniu	•	
Baltimore,	permit. Depertra Importa eny Inju		21. Signature of Fune al Service Licens			22	. Name ar rkvill	d Addres e 880	Evensii O Harf	Funer ard F	al Chapel d. Parkvi	l & Cren ille, Mi	ation 9 21234	Services
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006	e law re hes bee ge 2 sho	Completed									24a. Was		b. Were au	topsy findings available completion of cause of
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of/	hys this al dii	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 11 Inpatie		ER/Outpatier 28b. Time o			4 140		me 5 Resident			cify)
uo	B 5 6	tion	1 Natural 5 ☐ Pending	(Month, Da	y Year)	Injury	м .	28c. Injun Worl 1 □	k? Yes 2□		200. 00001100	ion injury oc	ourrog	
Division of Vital Records,	Attending or death. ector: After by the fune	fical	3 Suicide 6 Could not be	289. Place of Inj	ury - At h	ome, farm, str							umber or Ru	ral Route Number,
Ö	s after al Dire	Certification;	4 Homicide determined	building, et	c. (Specif	y) 					City or To	vn, State)		
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fu	dical	(Check only 2 Medical Exam	iner: On the basis o and manner st	f examina	tion and/or in	vestigation	, in my o	pinion, dea	th occur	red at the time,	date and pla-	ce, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			_	29	c. Licens	e number			29d. Date si	gned (Monti	n, Day, Year)
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	5		29b. Signature and title of certifier Bhauneeflea 30. Name and address of person who a Bhauneet B 31. Date filed (Month, Day, Year) MAR 2 7 2	completed cause of c	JC C	n 23a) (Type,	Print)	rven	blv	d, B	altim	ore 1	1D 2	21239
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 7 2	32 Registr	ar's Signa	ature A	and!					7		

Deborah Juniata '	11	eatley Si - For State Registrar	tate of Maryla	nd / Departm <i>Certific</i>			nd Menta	al Hygi		. No.	2007	7 0965
Physicia Medical Examin	n/	1. Decedent's Name (First, Midd Deborah Juniat						I N	Date of Death Month 1 March 25, 2	Day 20 0 7	Year	3. Time of Death 0704 hrs
		4a. Facility Name (if not institution 7005 Gough Street				4b. City, Town, o Baltimore	or Location of	Death			unty of Death more Cou	nty
Funeral Director		5. Social Security Number 218-62-2675	6. Sex 7	7. Age (In yrs. last birt	hday) Yrs	If Under 1 Ye Months Da		Min	Date of Birth		Foreig	hplace (State or n untry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c, City, Town	or Locat	ion						10d Inside City Limits
Maryland 28a-f show any d at once.	į.	Maryland Balt 10e. Street and Number	imore	Balt	imo	re 10f. Zip Code			1100	Citizen	of What Cour	1 Yes 2 X No
the Mar	E e	7005 Gough Str	eet			21224	1			,	ed Stat	•
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- injury or other traumatic event, the Medical Examiner must be notified at once.	— L	11. Marital Status										can Indian, Black,
s after c	≱⊦		vorced If Yes, Give Year or Dates:			Yes 2 X N		ind of work	done I	Spec	of Business/Ir	
72 hour	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)		7		ost of working lif			done	IOD. KING	01 84311633/11	iduotiy
21215-0036 July be filed within 7 I Mental Hygiene . marked other than ic event, the Medical	dwo	12 years	Lott	F	Iomei	maker	18 Mother's	Name /Fire	st, Middle, Ma		1 Home	
215- e filed tal Hyg ked off	ğ Be	17. Father's Name (First, Middle Stanley Ritter						se Ro		alderi Odir	iame)	
21, should be and Men is mar	P	19a. Informant's Name/Relations	ship (Type, Print)	1		Address (Stre	eet and Numb	er or Rural	Route Numb			
MD and 2 sho fealth and tem 27 is	ŀ	Kandra Taylor 20a. Method of Disposition	(Daughte	20b. Place of	of Dispos	Wallfor ition (Name of c		ve Di			cyland tion - City or	
Baltimore, ocmit Pages I an Department of He Important: If ite		1 Burial 2 Crematio 4 Donation 5 XXOther S		III State	•	her place) n_Cemete	rv	3/29	/2007	Balt	imore.	Maryland
Saltil ermit Departm mporta	- 1	21. Signature of Funeral Service	Licensee		22. N Di	lame and Addre	ss of Facility Funer	ral Ho	ome of	Dund	dalk, 1	Inc.
Physician	\dashv	23a. Part I. Enter the disease, o	r complications that cal	used the death. Do no	70 ot enter t	922 Wise he mode of dyin	g, such as car	te Di	undalk piratory arres	Mar t, shock, c	ryland orheart	21222 pproximate Interval Between Onset and
Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a Multiple	drug (metha		venlafax	rine, no	rtript	vline ar	d cyc	Lobenzar	
	ا <u>ة</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):							_	
ecuted and transit	a E		d									
e be executed ysician and burial - transit	ledical	X UNPENDED		-28a-f, perM	E, g8	67 , 5/15/	'07IT			23d Da	ate of delivery	
certificat	sician/M	IF FEMALE: 23b. Was decedent pregnant in topast 12 months? 1 Yes 2 No 9 V Ur	the 1 Live bir	int at time of death		ital death 3	Ectopic	pregnancy		Mor		ay Year
Records, P.O. Box The law requires that the death cate has been signed by the atterpage 2 should be detached for the control of the control	Phys	Part II. Other significant condi	3 OTIKITO		g in the i	underlying cause	given in Parl	t I.	23e. Did tob	acco use	contribute to t	he cause of death?
, P.C res that signed I be deta	à							_	1 Yes			ably 4 🗹 Unknown
of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	Completed							_ 1	24a. Was ar autopsy perform	/		copsy findings available completion of cause of
Rec The 1a ficate h	팅.					OC DI-		Charle ank	1 Yes 2		1 🗸 Ye	s 2 No
/ital /sician:	o Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	Hoonital:	patient 2 ER/O	utpatient		Other	Nursing Ho		esidence	6 🗸 Other	: Scene
of \ing Phy	⊢ t	27. Manner of Death		of Injury 28b. Day,Year)	Time of		jury at Work?	1	d. Describe ho	w injury o	ccurred	
Sion Attendi r death. ector: by the f	catio	2 Accident Inve	290 Place	25/2007 FNd of Injury - At home, fa	6:55	am	Yes 2 X		unk Location (St	reet and N	lumber or Rui	ral Route Number, City
Divi	Certification:	3 Suicide 6 X Cou	uld not be ermined (Specify)	found at h				l	or Town, Sta		Dundalk	, MO
Division of Vital Rec Vitin 24 hours after death. To the Funeral Director: After this certificate b completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex.	Physician: To the best aminer:On the basis o and manner st	f examination and/or i	ath occu	rred at the time, tion, in my opini	date and place on, death occ	ce, and due curred at the	e to the cause e time, date a	(s) and mand place, a	anner as state and due to the	ed e cause(s)
F. 2 F. 8	Me	29b. Signature and title of certif					nse number				signed (Mor 25, 2007	nth, Day, Year)
~		30. Name and address of perso	n who completed real	Thu aud	2		/.IVI. L.			march.		
ð		Theodore M. King, Jr	., MD. Assista	nt Medical Exam		111 Penn S	Street, Balt	timore, N	MD 21201			
Sta Regist	ate rar	31. Date filed (Month, Day Year MAR 2	2007 Rec	gistrar's Signature	9004	W.						
									-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 09555

		- For State Registrar		C	ertific	ate of	Death			R	eg. No.		7 5 5 6
Physiciar		Decedent's Name (First, Midd	le,Last)						2	. Date of Dea	th		Time of Death
Medical Examin		KURT					WALKER			Month March 24	Day Year 2007		1539 hrs
•••		4a. Facility Name (if not institution Northwest Regional H		umber)		41	. City, Town, or L Randallstow		of Death		4c. County o		y
Funeral	T	5. Social Security Number	6. Sex	7. Age (In yr	s. last birt	hday)	If Under 1 Year		er 24Hrs.	8. Date of Bi	th(MM/DD/YYYY)		ace (State or
Director		216 -66-2262	1 X M 2 F		48	Yrs.	Months Days	Hours	Min.	08/25	/1958	Foreign Count	y) PA
	ŀ	Usual Residence of Decedent	00/20/200										
any	Γ	10a. State 10b. County		10c. C	ity, Town	or Locatio	n					10	ld. Inside City Limits
nd show	۱	MD BALTI	MORE		OWIN	IGS M	ILLS					1	Yes 2 No
daryland 28a-f show any 1 at once.	ᇎ	10e. Street and Number			.,		10f. Zip Code			1	0g. Citizen of Wh	at Country	?
ith the Maryland 23a or 28a-f sho notified at once	Director	5 LEICESTER (COURT			1	21117				U.S.A	Δ	
with 15 23 se no		11. Marital Status	12. Was De	cedent Ever in	U.S.		Decedent of Hisp				14. Race	- Americar	Indian, Black,
leath r iten	Funeral	1 Never Married 2 X M	arried Armed F	Forces?	,	If Yes	s, specify Cuban,	Mexican,	, Puerto R	ican, etc.)	White	, etc.	
ifter o	b A	3 Widowed 4 Div	orced If Yes, Give Ye			1 📗 🕥	res 2 X No	specify:			Specify:	WHI	TE
		15. Decedent's Education (Spe		ade completed			Usual Occupation				16b. Kind of Bus	siness/Indu	istry
72 h	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		during mos	st of working life.	DO NOT	use retire	۵)			
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	ᇍ			2	DE	PARTI	MENT MAN				S0L0 (CUP	
P 2 2 2 4 (ပ	17. Father's Name (First, Middle	, Last)						,	First, Middle, I	Maiden Surname)		
2121 Ild be fi Mental I	8	DIVAD	L			ALKER		ROBI				HARR	
Should Mand Marie and Marie	۱	19a. Informant's Name/Relations									nber, City or Town		
ore, MD 21214 St land 2 should be file of Health and Mental F If item 27 is marked her traumatic event, I	ŀ	ROBIN WALKER 20a Method of Disposition	/ WIFE	120			on (Name of cem			Date	MILLS, N		
nore, MD 2 ages I and 2 shou nt of Health and N t: If item 27 is n other traumatic			n 3 Removal f	1		ory or othe		Cici y,		Bate	200. Eddallari	Oity of To	TI, Oldio
im Pag ment tant:		4 Donation 5 Other S		DF	RUID	RIDGE				7/2007	BALTIMO	ORE,	MD
Baltimore, permit. Pages I a Department of He Important: If ite injury or other ti		21. Signature of Funeral Service	Licensee			22. Na	me and Address	of Facility	sc.	L LEVI	NSON & E	BROS.	, INC.
	4	23a. Fart I Enter the disease, or			oth Dono	180	000 REIS	TERS	TOWN	ROAD -	PIKESVI	LLE	MD 21208
Physician /Medical		failure. List only one cause	on each line.				riflode of dying, s	suu i as c	alulac oi i	espiratory arr	est, shock, of flea	" '	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)				mbosis							Deatr
~ n' *			,	a consequenc ive Atheros	,	c Cardio	vascular Dise	ease					
	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequenc		-							
	틹	cause. Enter Underlying Cause (Disease or injury that initiated	C										
ed nsit	Examiner	events resulting in death) Last	Due to (or as	a consequenc	e of):								
760, Icate be executed physician and the burial - transit	/Medical	UNPENDED	d. X AMENDED	erINF, g	066	. /2 /07	TT			-	_		
Records, P.O. Box 68760, The law requires that the death certificate be exteated has been signed by the attending physician page 2 should be detached for use as the burial page.	影	IF FEMALE:	#J, P	outcome of p			11				23d. Date of	delivery	
587 rrtifica ling p	a	3b. Was decedent pregnant in the past 12 months?	LIVE	birth		Feta	I death 3	Ectopio	c pregnanc	СУ	Month	Day	Year
Box 687 e death certificate attending ed for use as t	힔			nant at time of	death	5 Othe	er (Specify)						
that the derected by the set detached for	Physician	Part II. Other significant condit	9 Oliki		nt resultin	a in the un	derlying cause di	ven in Pa	art I	23e Did to	obacco use contrit	oute to the	cause of death?
ires that the signed by the detach	2	Part II. Other significant condi-	contributing	to death but he	or resultin	g iii tile uii	derry ing cadse gi	VOIT III T	21 (1.				y 4 🗸 Unknown
S, I										24a. Was			sy findings available
cords law requil has been: 2 should	Completed									autor	osy pi	rior to com	pletion of cause of
Aec The I	ξĺ											✓ Yes	2 No
tal Recian: The certificate ector, page	Be	25. Was case referred to medica examiner?						Ahar:	(Check on				
Vit hysic rthis	eL	1 ✓ Yes 2 No	Hospital: 1			utpatient			Nursing		Residence 6	Other:	
ion of Vital I		27. Manner of Death 1 ✓ Natural 5 People	(Mont	e of Injury th, Day,Year)	280.	Time of Inj	· I ·	es 2	.	od. Describe	how injury occurre	eu	
sior ttend death ctor:	∄		stigation							05 (Otrock and Number	n and Donald	Davida Niverbox City
Division of Vital Records, pital or Attending Physician: The law requing ours after death. eral Director: After this certificate has been so the pite of the pite	Certification:		ld not be		t home, fa	arm, street	factory, office bu	aliding, et	ic. 2	or Town, S		r or Rurai	Route Number, City
E 8 E E (<u>ق</u> ا	4 Homicide	(open)								(-)		
	<u>8</u>	Check only Certifying P	hysician: To the beaminer:On the basis	est of my know of examination	ledge, de in and/or i	ath occurre investigation	ed at the time, day on, in my opinion,	te and pla death oc	ace, and d curred at t	ue to the cau: the time, date	se(s) and manner and place, and di	as stated. ue to the c	ause(s)
To the within 7 To the complet	Medical	29b. Signature and title of certific	and manner				29c. License				29d. Date signe		
		100 4 2	0 d	10		0	O.C.N				March 25, 2		
7	L	Cer Co	7	ta	<u> </u>	ul							
10		 Name and address of persor Carol Allan, MD As 	n who completed car ssistant Medica			Penn S	treet, Baltimo	re. MD	21201				
Sta		31. Date filed (Month, Day, Year)	~	Registrar's Sign			,	,					
Registr	œ.	MAR 2 7 20	07 Marca	W.		3455							
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		1	For State	State	of Maryland	d / Depa <i>Cer</i>	rtment tificate	of He	ealth ar Death	nd Me	ntal Hy	/giene Reg. No.	()	09656
_			Registrar . Decedent's Name (First, Midd	le, Last)						2	2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia			.son							March			8:20 a ^M
	/Medic	21	Dorris Will la. Facility Name (If not institution		umber)		4b. City,	Town, or	Location of	Death		4c.	County of Dea	th
)	Examin	er '					Coli	mbia	7				Howard	
			11808 Bare Sky	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 24	4 Hrs. 8 Min.	B. Date of B (Month, L	irth Dav. Year)	9. Bir	thplace (State or Foreign ountry)
	Funeral	1	215-22-1349	1 □ M 2 T F	80	Yrs.	Months	Days	Hours	IValiti.	FEB 2	4, 19	927	MD
	Director	+	Usual Residence of Decedent											10d. Inside City Limits
3	show ed at		10a. State 10b. Count	у	10c. City	y, Town or Lo	cation							1 □Yes 2√□No
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:	r 28a	irec	10e. Street and Number				10f. Zip					10g. Cit		
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	ms 2	Funeral Director	11. Marital Status	12. Was Do	ecedent Ever in U. Forces?	.S. 13.	Was Deced If Yes, spec	lent of Hi city Cuba	ispanic Origi in, Mexican,	in? (Spec , Puerto R	city Yes or I lican, etc.)	No-	Black, Whi	
0	or ite		1 ☐ Never Married 2 ☐ Ma	If Yes.	s 2.[XNo Give		1 ☐ Yes	2X No	Specify:				Specify: W	hite
3	ral",	by	3 XWidowed 4 ☐ Divorce		Dates:	16a Door	dent's Usua	al Occurs	ation			16b. K	and of Business	
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V	ygier ygier her th	3	12 17. Father's Name (<i>First, Middle</i>	e / ast)) OIE	LK LY		18. Mother	r's Name	(First, Midd	lle, Maidei	n Surname)	
פ	<u>a a a s</u>	Be		gmann					Els:	ie	Armst	rong		
<u>X</u>	should be f and Mental I s marked or umatic eve	မ	19a. Informant's Name/Relatio			19b. Mail	ng Address	(Street	and Numbe	er or Rural	l Route Nui	nber, City	or Town, State,	, Zip Code)
	2 sh n and ris n		Debbie Wilson		er	1			y Lane					
e o	es 1 and 2 should b of Health and Ment Item 27 is marked r other traumatic e	100	20a. Method of Disposition	анабие	20b.	Place of Disp cemetery, cre			-		ate	20c. L	ocation - City o	or Town, State
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a a	permit. Departr Imports any Inj		21. Signature of Funeral Servi	even H. W	illiams		MacNa 301 F	bb f rede	unera. rick l	Road.	ne, P	.A. onsvi	11 <u>e, M</u>	21228
	ED = # 0		23a. Part1. Enter the disease, shock, or heart failure.	or complications th	at caused the dea	th. Do not er	nter the mo	de of dyir	ng, such as	cardiac o	r respirator	y arrest,	20101-110	Approximate Interval Between
٦			shock, or heart failure. L	ist only one cause	on each line.	· S.O	. 4	,	Carol	inV	11000	no I	000000	Onset and Death
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1	/Medical Examiner			Due	to (or as a conse	qualion 01).								
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	and al-tra	Examiner	resulting in death) Last	C	to (or as a conse	quence of):								
760,	death certificate be executed e attending physician and ed for use as the burial-transit	calE												
687	phys the			u										
×	leath certificate attending phy: I for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes	, outcome pf preg	nancy	Ectopic	prognanc	21/				23d. Date of o	delivery Day Year
Box	atten for u	ciar	in the past 12 months?	4□P	ive birth 2□Fe regnant at time of		Other (·y			_	MOTH	Day
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₹	9 9	Be	examiner?	Hospital:	1 ☐ Inpatient 2	☐ ER/Outpat	ient 3 🗆 1	OCA OT	ther: 4□N	lursing Ho	ome 5 🔀	Residence	6 ☐Other (S	Specify)
o	Phys r this rral di	- P	27. Manner of Death		Date of Injury (Month, Day Year)	28b. Time Injur		28c. Inju	ury at		28d. Desc	ribe how in	ijury occurred	
no	ding F. After funer	tion	1 Natural 5 ☐ Pe 2 ☐ Accident	nding estigation	(MOHIII, Day Tear)	1 11,01	M]Yes 2□]No				
Si	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Co	uld not be termined 28e. I	Place of injury - At building, etc. (Spe	home, farm,	street, fact	ory, office	9		28f. Locati City o	on (Street r Town, St	and Number of ate)	r Rural Route Number,
Division	l or Attend after death. Director: /	Certification:	4 Homicide	}										
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by		29a. Certifier 12 Cert	ifying Physician: T	o the best of my k	nowledge, de	eath occurr	ed at the	time, date a	and place, eath occu	, and due to rred at the	the cause time, date	e(s) and manne and place, and	er as stated. due to the cause(s)
	e Ho 24 h e Fu	Medical	(Check only 2 Med one)	and	manner stated.									fonth, Day, Year)
	To th Withir To th	Me	29b. Signature and title of ce	rtifier	(A)	4.4			nse number	77	1	100	LAT G	234 2007
	, ,, ,		•	5	000	· M	0	D (76 00	102	/	11/0		25-8001
	2		30. Name and address of pe	rson who completed		tem 23a) (Ty	pe, Print)	, ,		`\	St 2	06	1 MILDE	MAN DATAC
	9		SYED S	AND	4333	daun	ells	9W/6	LK	.0.	212	00,0	X MUOUS	E 4110 00 108
	S	tate	31. Date filed (Month, Day,	· ·	32. Registrar's Si	gnature	Land	20						
	Regis	strar	MAD	2 7 2007	E Parada	J.	LANGE							

DHMH 17 Rev 1/2001

07-02176 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shawn Lamont Weaver State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Day March 21, 2007 0406 hrs Medical Examiner Shawn Lamont Weaver 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death University Hospital Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** Director 220-23-1409 05/14/1989 17 Country) MD 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 X Yes 2 No MD Baltimore 23a or 28a-f shov notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 128 North Bethel Street 21231 Funeral Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, X Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married 2 X No Yes African American If Yes, Give Year 1 Yes 2 X No specify: Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 21215-0036 unknown of Health and Mental Hygiene If item 27 is marked other the unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 127 is marked umatic event, t Be Shawn Lamont Weaver, Sr. Tammy Cost ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Cost / Mother 128 North Bethel Street; Baltimore, Maryland 20a. Method of Disposition
1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date timore, crematory or other place) Mount Zion Cemetery 03/29/2007 Baltimore, Maryland Donation 5 Other Specify: permit. 21. Signature of Funeral Service Licensee Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 23a Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last law requires that the death certificate be executed attending physician and or use as the burial - tran sician/Medical UNPENDED AMENDED 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phys 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ğ 1 Yes 2 V No 3 Probably 4 Unknown م Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 No 2 No page 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: 1 / Inpatient Other₄ Nursing Home 5 ER/Outpatient 3 DOA Residence 6 Other: 2 this ۵ 1 V Yes 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Mar 21, 2007 Subject was shot Division Natural 1 Yes 2 ✔ No 5 Pending the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) 900 McCulloh St., Baltimore, MD determined (Specify) Local Street 4 V Homicide

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director:

29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 22, 2007 O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner

32. Registrar's Signature

31. Date filed (Month, Day, Year, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** R WILSON 03 24 338AM WOLREN 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia toward HUWARD COUNTS GENERAL MOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1X M 2□ F 84 Min. Days 218.14.76.35 Director June 7, 1922 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notifled at Maryland Howard 1 ☐ Yes 2 No Ellicott City Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 'natural", or Items 23a or dical Examiner must be r 2809 Deer Trail Court 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amled Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) industrial steamfitter the Ith and Mental Hygie

27 Is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Wilson Carrie Crockett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 Is any injury or other trauonce. 2809 Deer Trail Court Ellicott City, Maryland 21042 Mr. Warren W. Wilson Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 03/29/01 Columbia, MD St. John's Lutheran Church 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral S Nice Licens 6 Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as consequence of): Physician 2 WEEFS /Medical Examiner Steron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by PNEUMONIA 2 No 3 Probably 4 Unknown page 2 should COPO 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res 2.22 No DEMENTIA 1∏ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24 2007 MAR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 CEDAN LANE YUSPIN MD JEREMU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 25 3:15 AM Physician 2007 MArch Barbara Eileen Yelton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Dove House Westminster 8. Date of Birth Sept. 7, 1941 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days Hours Min 1 □ M 2 X F 218-40-2081 65 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State r 28a-f show notified at 1 ☐ Yes 2 XNo MD Carroll Westminster Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 2 USA 21158 305 Greengate Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married 0 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify SpecifiWhite þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Lorien Nursing Home Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred R. Scott William Reubin Forwood ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Grove Lane Westminster MD 21157 Sherri Reese /daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Meadow Branch Cemetery 3/28/07 Westminster MD 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel 6009 Harford Road Baltimore MD 21214 Approximate Interval Between Onset and Death ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or composhock, or heart failure. List only of 3ARC Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequer ce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery þ Completed

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the nosping after death, within 24 hours after death.

To the Funeral Director: After the function of the f

Be (

Certification: To

Medical

29b. Signatur

31. Date filed (Month, Day,

d title of certifier

23b. was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)	Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underly	Ing cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical		26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3[□ DOA Other: 4 □ Nursing Hor	ne 5□Residence 6 Øother (Specify) POVE HCV
27. Manna of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work?	8d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office	8f. Location (Street and Number or Rural Route Number, City or Town, State)
			and due to the cause(s) and manner as stated. End at the time, date and place, and due to the cause(s)

29c. License numbe

29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001 who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 05:45 AM Charles Edward Zulauf, Jr. 2007 4c. Counfy of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Kosedale Haspita 8. Date of Birth (Month, Day, Year) 08/23/1930 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number L 7. Age (In yrs. last birthday) Maryland Days Months 76 215-28-6949 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 X No Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 U.S.A. 213 Virginia Avenue 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1XXes 2 No If Yes, Give Korea Year or Dates: 1 Never Married 2KM Married 1 ☐ Yes 2 ☑ XNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Law Enforcement Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gazella Arminger Charles Edward Zulauf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 213 Virginia Avenue, Essex, Maryland 21221 Lou Ann Zulauf (Wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 03/26/2007 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, meart faile Immediate ause (Final Intracranial evere disease condition resulting death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2□ No 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Important: If item 2 any injury or other once.

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

is marked other than "natural", or iten aumatic event, the Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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To the Hospitai or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the a certificate After this within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

filled in by Medical

Examine Physician/Medical Completed by Be Certification: To

IF FEMALE

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending investigation 2 Accident

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

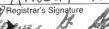
29d. Date signed (Month, Day, Year) MARCH 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

9000 Franklin Square Ofori-Awuah

State Registrar 31. Date filed (Month, Day,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl 2<u>007</u> Month **Physician** 23:16 March 23, Henry R. Aaron /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 11, | Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Massachusetts 84 Director 022-12-7949 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examinar months. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 15111 Glade Drive United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: by White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Veteran's Administration 12 Supplies Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ursala Sylvia Matz Harry Aaron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glade Dr., Silver Spring, Maryland 20906 Bertha Aaron Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 29. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2007 Silver Spring, Maryland 4 □ Donation 5 ☑ Other (Specify) entombment 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland 20850 M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Coxonsuy /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Hrknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 → No 24a. Was an page 2 s autopsy performed' certificate 2 A No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi complete(y filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 139793 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Coince Chilstopher J. Mays, MD dusy Philip do. MD 20832

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year).

P.O. I

Division or Vital Records,

32. Registrar's Signature

			1 - State Registrar Amend #12 Per at First Co	1861 and 376	partment of He Certificate of De	alth and Mental H <i>eath</i>	ygiene Reg. No. 2	7 09662
		Q	Decedent's Name (First, Middle, Last)			2. Date of I	Death	3. Time of Death
	Physicia /Medic	_	James	Weldon	Biddle		Day Year Year 22 0	. 0.4
	Examin		4a. Facility Name (If not institution, give street and number,		4b. City, Town, or Lo		4c. County of De	ath
		<u> </u>	2525 Pennsylvania			altimore fUnder 24 Hrs. 8. Date of B	Siate D D	Ab-J
	Funeral Director		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birtho	Months Days	Hours Min. (Month,	Day, Year) (inthplace (State or Foreign Country)
100	Allester and Allester		Usual Residence of Decedent	0.2		1 09-	20-1944	V a
	ryland how		10a. State 10b. County	10c. City, Town of				10d. Inside City Limits
	e Ma Ba-f s	Director	Md	Balt	imore			1 X }Yes 2 ☐ No
	vith th	Dire	10e. Street and Number	_	10f. Zip Code	17	U.S.A	Country?
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heatth and Mental Hygiene. It heatth and Mental Hygiene. It was 23a or 23a-f show then 27 is marked other than "natural", or Items 23a or 23a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	2525 Pennsylvania 11 Marital Status 12. Was Decedent		212			nencan Indian.
	ter de	Fun	Armed Forces' 1 Never Married 2 Married 1 Nases 2 □	No 1967 –		anic Origin? (Specify Yes or I Mexican, Puerto Rican, etc.)	Black, Wh	
	al", or	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1970	1 □ Yes 2 □ No S	Specify:	Specify:	Black
5	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occupation	on ina most of workina	16b. Kind of Busines	
7	ithin he.	nple	Elementary/Secondary (0-12) College (1-4or	5+)	ife. DO NOT use retired)	o o	Dept of	the Army
7	led w lygier her th		12th 17. Father's Name (First, Middle, Last) 6year	s Envi		Hygienic Te		
2	be fill	Be	17. Fathers Name (First, Middle, Last)		18	3. Mother's Name (First, Midd		
Ž	should be filed within 72 ind Mental Hygiene. Imarked other than "nat umatic event, the Medica	凸	Stephen Edward Biddl 19a. Informant's Name/Relationship (Type. Print)		Aailing Address (Street and	Johnnie R. d Number or Rural Route Nur.		
<u> </u>	od 2 sho tth and 27 is ma trauma							
נֿע	is 1 and 2 of Health Item 27 other tra		Ruth Greene - sister 20a. Method of Disposition	20b. Place of D	Disposition (Name of	a Dr. Balto	Md 21207 20c. Location - City of	
2	Pages nent of int: If It		1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify))	ciematory or other place)	3/24/07	Balto. M	ıd
	그 등 명 등		21. Signature of Funeral Service Licensee	1 2200	22. Name and Address	of Facility	5240 Reist	
Ď	permi Depar Impol any Ir		Teres they		Chatman-Ha		Balto.Md 2	
	river 1		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do no line.			arrest,	Approximate Interval Between
	Physician				neer m	chastatic		Onset and Death
r e ja	/Medical		resulting in death) Due to (or es	a consequence of)		ctastatic vicarum pri	01	9000
	Examiner		Sequentially list conditions.			VENTONA PILLI	na q	gears
	pe tisi	Examiner	cause. Enter Underlying	a consequence of)				
	and al-trar	хап	Cause (Disease or injury that initiated events c Due to (or as	a consequence of)	:			
	icate be executed physician and s the burial-transit	dical E						
	ificate g phy as the		- J.					
5	w requires that the death certif been signed by the attending should be detached for use as	sician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	e pf pregnancy 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of d	
	deat ne atte	sicia	In the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant a	at time of death	5 Other (specify)		Month	Day Year
	at the by the	Phys	9 Unknown					
Ď	res th	by	Part II. Other significent conditions contributing to death	out n ot resulting in ti	ne underlying cause given		d tobacco use contribute □ Yes 2 □ No 3 □ I	Probably 4 Unknown
5	requi	Completed						. 7
ב	e law has b	현			-			autopsy findings available completion of cause of
all	r. Th					1 Yes	3 2 No 1 □ Ye	
5	sicial certii recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outp	Other	6. Place of Death (Check onl	, , , , , , , , , , , , , , , , , , , ,	
5	ding Phystclan: The lav n. After this certificate has funeral director, page 2.	-	27. Manner of Death 28a. Date of Inj	ury 28b. Tir	ne of 28c. Injury a	4 ☐ Nursing Home 5 X Re t 28d. Describ	e how injury occurred	еспу)
5	nding th. r: Afte e fune	tio	1 Natural 5 □ Pending (Month, Dia 2 □ Accident investigation	ay Year) Inji		s 2□No		
2	After er dea rector by th	iffice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of in building, e	jury - At home, farm	n, street, factory, office		(Street and Number or I	Rural Route Number,
5	tal or safter all Direction	Certification:		(5,4)/				
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis	of examination and/	death occurred at the time, or investigation, in my opin	date end place, and due to the dialon, death occurred at the time.	he cause(s) and manner he, date and place, and d	as stated. ue to the cause(s)
	the I	Med	one) and manner s	tated.	29c. License n	umber	29d. Date signed (Mo.	nth Day Year)
	5 × 5 0	-	29b. Signature and title of certifier		NS	8303	March a	
	12		20. Name and address of names who completed acres of	death (Item 22a) /T-	(ne Print)	,		
L	1		30. Name and address of person who completed cause of	1) 670	(N. Chance	1 St Ponsu	N MO 217	104
	Sta	te	31. Date filed (Month, Day, Year) 32. Regist	trar's Signature				
			MAR 2 8 2007	M And				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amelia Lynn Boseman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **Medical Examiner** 2308 hrs Amelia Lynn Boseman March 23, 2007 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bon Secours Hospital 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** June 11,1962 oreign Maryland 215-88-5891 Months Days Hours Min Director M 2X F Usual Residence of Decedent 10a State 10b. County Town or Location 10d. Inside City Limits N/A Baltimore Marylan¢ 1XXYes 2 No 28a-f shov or items 23a or 28a-f show must be notified at once. 0g. Citizen of What Country Directo 10f. Zip Code 21217 10e. Street and Number 1904 Harlem Avenue Funera 11. Marital Status 14. Race - American Indian, Black, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? Never Married 2 Married Yes 2X No Black 1 Yes 2XXNo specify. If Yes, Give Year marked other than "natural", c event, the Medical Examiner 3 Widowed 4 Divorced Specify: è imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours. 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry eted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home Compl 8th GNA 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) item 27 is marked r traumatic event, James Skinner Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 35th St. Baltimore, 502 E. Carroll Adams / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
King Memorial Park 1 X Burial 2 Cremation 3 Removal from State Ξ 3/31/07 Woodlawn, Md tant: 4 Donation 5 Other Specify:
21. Signature of Funeral Service Licensee 22 Name and Address of Facility Chatman-Harris Funeral Home <u> 5240 Reisterstown</u> Rd Baltimore,Md21215 23a. Par I. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filters. List only one cause on each line. Physician Between Onset and , /Medical Death Cardiac arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Severe anemia Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit sician/Medical X AME#8,23a-b,27,per FH, ME, g867, 5/16/07 TT X UNPENDED of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be-IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth signed by the attending be detached for use as Fetal death Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 V No 3 Probably 4 Completed After this certificate has been a funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? No 2 No ✓ Yes 2 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital. 1 Other₄ 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 1 X Natural 1 Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined

Hospital or Attending Physician: 24 hours after death. neral Director: / Funeral To the

(Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b. Signeture and title of certific

O.C.M.E.

March 24, 2007

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD.

2007

gistrar's Signature

State

Registrar

one)

31. Date filed (Month, Day, Year)

MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For Amend #14, perF		TT Cer	tificate of De	eath	Reg.	No. 200	7 09664
er.	Physici	an	1. Decedent's Name (First, Middle, Las	equiv				Date of Death Month	Day Year	
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or L.c		Kurch 2	4c. County of De	1
	LXuiiiii	4 4	Nontenesst	Hospital		Roude	listous	^	Baltin	NONT
	Funeral Director		N/A	7. Age (In yrs.	last birthday) Yrs.		Hours Min.	Date of Birth (Month, Day, Ye 2 01	ear) (rthplace (State or Foreign Country) Pakistan
000	at ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	cation				10d. Inside City Limits
Mon	a-f sh ified	ctor	MD Baltin	nore		Owings	Mills			1 □ Yes 2 📉No
4	ns 23a or 28a-f show must be notified at	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What (Country?
4	ns 23a must	Funeral	102 Summerwoods	3 Way 12. Was Decedent Ever in U.	e 12 W		117	Ves ex Ne	Pakis	
5-0036	be lifed within 7.2 hours after death with the Maryland Hygiene, ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2/2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1		Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 2X No 5	Mexican, Puerto Ric	ean, etc.)	Black, Wr	
် ဂ်	"natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	ent's Usual Occupation kind of work done duri O NOT use retired)	on ing most of working	166	. Kind of Busines	s/Industry
Z :	than than he Me	James	Elementary/Secondary (0-12) N/A	College (1-4or 5+) N/A		nemploye			Unemi	oloyed
שלים קיים	other other rent, t	Be Cc	17. Father's Name (First, Middle, Last)	IV/ A			B. Mother's Name (F	irst, Middle, Maid		
/lar	Menta narked natic ev	To B	Ghullam Rasool				Fatima I	Bibi		
Mar	ls ma		19a. Informant's Name/Relationship (7	ype. Print)		g Address (Street and				
ָבּ קי	or other traum		Sami Khan-Son 20a. Method of Disposition	20b. P			ods way		Location - City of	s, Md 21117
	ent of nt: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval nom state		nation (Name of natory or other place) orial Pa			•	town, Md
	Department of Important: If any injury or once.	l î	21. Signature of Funeral Service Licens		22.	Name and Address of	of Facility	/O/ Re	illuaris	COWITY THA
פֿ מ	Depa Impo any ir	ii, i	I flome of	4. Thompso	Ma 43	rch F/H 00 Wabas	west h Ave, 1	Baltimo	ore, Md	21215
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death one cause on each line.	n. Do not ente	er the mode of dying, s	such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myscac	gral.	In fac	gian			Onset and Death
	xaminer			Due to (as a consequ	uence of):	100 T.	- -			2 mills
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uerice of).	1	7621			
ecuted	ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Derbet	5 1	le//ity				(5 years
e ex	ician a		Todaming in dodain) Edde	Due to (or as a consequ	ience of):	·				15:4-00
oo/oo	ig physician and as the burial-transit	Aedical		d	71 /1					1 7 8 7
DIVISION OF VITAL MECOLOS, F.O. DOX 06/00, To the Hospital or Attending Physician: The law requires that the clearly certificate be executed.	been signed by the attending should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Wo 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	Ideath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of do Month	elivery Day Year
o, ⊓	gned b	by PI	Part If. Other significant conditions co	entributing to death but not resu	ılting in the un	derlying cause given i	n Part I.	23e. Did tobaco	co use contribute	to the cause of death?
w requires t	en siç							1 ☐ Yes	2 7 √0 3 □ F	Probably 4 Unknown
The law	n. After this certificate has bu funeral director, page 2 st	Completed						24a. Was an autopsy performed 1 Yes 2 D	prior to death?	
VII.	certifi	Be	25. Was case referred to medical examiner?	Hospital:		Other:	6. Place of Death (C			
5 £	eral di	.T	27. Manner of Death	28a. Date of Injury	R/Outpatient 28b. Time of	3 DOA Other. 28c. Injury at Work?	4 ☐ Nursing Home 28d	5 Residence Describe how in		ecify)
di di	ath.	atio	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		2 □ No		, ,	
i or Atte	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	28f.	Location (Street City or Town, St	and Number or F ate)	Rural Route Number,
Hospita	within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medical Exam	sician: To the best of my know iner: On the basis of examinat	wledge, death tion and/or inv	occurred at the time, estigation, in my opini	date and place, and ion, death occurred	I due to the cause at the time, date	e(s) and manner a	is stated.
o the	o the	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License nu			Date signed (Mon	
F-	5 - Ö) /Q/	MD				M	1	
1	~					1377	2 V C		10 1-	200
2	7	-	30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, P	DY7a	7 00		MAG Q	72007
2	Stat		30. Name and address of person who co	ompleted cause of death (Item 32 Registrar's Signat	3 (0		5 Doir	e sings	325 Oi	NOSMISMS

DHMH 17 Rev 1/2001

			For State		State of I	Marylan			of Health a <i>of Death</i>	nd Ment	, ,		2007	nocce
			Registrar	/First Middle La	et)		Ce.	lineate	UI DeallI	2. Da	ate of Deatl	eg. No. (_001	3. Time of Death
	Physici	1. Decedent's Name (First, Middle, Last) Physician /Medical Nora						Bay	ter		onth	18 ^{Day}	20°07	
20			Nora 4a. Facility Name (If n	not institution give	e street and number	er)			wn, or Location of				County of Dea	
E,	Examir	er	Gilchris			.,		_	owson				Balti	
	Funeral	-	5. Social Security Nur			Age (In yrs. I	ast birthday)	t birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth				16 .	9. Bir	thplace (State or Foreign
I	Director		258-26-7 Usual Residence of D	344	□м 2√ F	89	Yrs.	Months D	Days Hours	Min. 05	nonth, Day, 21	Year)	7	GA
	land bw			10b. County		10c. City	r, Town or Lo	cation						10d. Inside City Limits
	Mary f sh	ţō	MD	NA		Ва	ltimo	ore						X□Yes 2□No
	the 28a- notif	rec	10e. Street and Numb					10f. Zip Co	ode		10	0g. Citiz	en of What Co	ountry?
	3a ol	Funeral Director	3627 Ros	alaha:	Road				21215				U.S.A	۸.
	ms 2	Jere	11. Mantal Status	Jeaure	12. Was Decede		S. 13.	Was Deceder	nt of Hispanic Orig	in? (Specify Y	es or No-	1	4. Race - Ame	
ယ	after or ite	Fur	1 □ Never Married	d 2 Married	Armed Force					Puerto Rican	, etc.)		Black, Whit	te, etc.
03	urs au", c	þ	3€ Widowed 4	Divorced	If Yes, Give Year or Date	s:		1 □ Yes 2 2	No Specify:			'	Specify: E	Black
2-0	72 hours after death with the Marylar "natural", or items 23a or 28a-f show ideal Examiner must be notified at	ted	(Specifi	15. Decedent's Ed y only highest gra	ducation		16a. Dece	dent's Usual (Occupation	of working	1	16b. Kin	d of Business	/Industry
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed	Elementary/Second	dary (0-12)	College (1-4c	or 5+)			done during most retired)	or working	-	2001	7 6-	ervice
2	filed withir Hygiene. other than ent, the M	Son	12th gra		na		50	ortor						ervice
Maryland	iges 1 and 2 should be filed within 72 hr nt of Health and Mental Hygiene. If Item 27 is marked other than "natu or other traumatic event, the Medical	Be	17. Father's Name (F	irst, Middle, Last)					18. Mother	's Name (First	t, Middle, N	Aaiden S	Surname)	
yla	should be fand Mental Band Mental Bands warked of umatic ever	2	Crawford	Dotso	n		Υ			e Gold				
lar	2 sho and is ma		19a. Informant's Nam	ne/Relationship (Type. Print)				treet and Number					
	Health tem 27 i		Sandra E		Daughte				edale R					
ore	of H		20a. Method of Dispos		Removal from Sta	te 20b. P	lace of Dispo e <i>metery</i> , c <i>re</i> i	sition (Name matory or othe	of er place)	Date	2	20c. Loc	ation - City or	Town, State
altimore,	Par Tier Land		4 ☐ Donation 5				rriso	n For	est Vet	3/30	/07	Owi	ngs M	ills, Md
Salt	permit. Pages 1 a Department of Hec Important: if item any injury or othe		21. Signature of Fund	eral Service Lice	see	/	M a	Name and A	Address of Facility H Wes	t				
8	20 E # 9		/ /)a	u 1	Nur	_	4.	300 Wa	abash A	ve, Ba			e, Md	21215
п			23a. Part1. Enter the shock, or heart	disease, or com failure. List only	plications that caus one cause on each	sed the death n line.				-				Approximate Interval Between
Ų.	Physician		Immediate Cause (Fi disease or condition	inal	a. Gr	ang	ren	2 01	regt As ce	A So	of			Onset and Death
J.	/Medical Examiner		resulting in death)		Due to or	as a consequ	uence of):	0		0	d -			
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	P #	iner	if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	nediate ying	Dueito (or	as a consequ	uence of):							
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	ertific ling p		IF FEMALE:		20- 15									
Box	leath certifi attending I for use as	Physician/M	23b. Was decedent p in the past 12 m			2 ☐ Fetal	death 3	Ectopic preg				23	3d. Date of de Month	livery Day Year
0	at the de by the a tached f	/sic	1 ☐ Yes 2 ☐1 9 ☐ Unknown	No	4□Pregnan 9□Unknow		eatn 5L	Other (spec	rty)					,
D	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as		Part II. Other signific	ant conditions of	ontributing to death	hut not resu	Ilting in the u	nderlying caus	se given in Part I	2	3e. Did toh	acco us	e contribute to	the cause of death?
Ś	ires t signe	by			7.4.	1 241 1101 1004	nung in the d	indonying odd	o given in raiti.	-	1 □ Ye		_	robably 4 □Unknown
oro	w require been signature	sted	0							_		,3	,110 0 1	
Record	e law has b je 2 sl	ald u								2	4a. Was ar autops	v l	prior to	utopsy findings available completion of cause of
E	(0 17	Completed								1	perform ☐ Yes 2	ned? No	death? 1 ☐ Yes	2 □ No
or Vital	Physician: The this certificate ral director, page	Be	25. Was case referre examiner?	d to medical	11					of Death <i>(Ch</i> e	ck only one	e)		11
7	Physic this cral dire	ို	1 Yes 2 N	ō	Hospital: 1 ☐ Inpa		ER/Outpatier			sing Home 5				city) to spice
E C		on:	27. Manner of Death 1 ☐ Natural	5 Pending		njury Day Year)	28b. Time o Injury		. Injury at Work?		escribe ho	w injury	occurred	•
Sig	Attending r death. ector: After by the fune	cati	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be				M	1 ☐ Yes 2 ☐ N					
Division	i or Attend after death Director:	Certification:	4 ☐ Homicide	determined	20e. Place of	injury - At ho etc. (Specify	me, farm, sti /)	eet, ractory, c	птсе	28f. Lo	ocation (Str ity or Town	reet and , State)	Number or R	ural Route Number,
	Hospital or 44 hours after Funeral Directly filled in the		One Codiffee	Continue	volcion. To the !-	ot of mirler:	ulodge do-t	h constraint : t	the time date of	I place i i	un de Alt-			
	T 2 F 2	edical	29a. Certifier 1 (Check only 2 one)	☐ Medical Exar	ysician: To the be niner: On the basi and manner	s of examinat	tion and/or in	vestigation, ir	my opinion, deat	h occurred at	the time, da	ate and	and manner as place, and du	e to the cause(s)
	ole ole	8			and manner									

nd manner as stated. lace, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MArch 19, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chales St. Balto. Mt 21204 GBMC 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 2 8 2007 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end item 7 per th 8865 3-28-07 vt.
State of Maryland 7 Department of Health and Mental Hygiene? 09666 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month $1:10A^{M}$ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ST. 1829 E.31st BALTIMORE CITY N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last highday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year)

NOV.13,1924

GEORGIA 1**X** M 2□ F -30-505 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits n/A BALTIMORE CITY X□Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1829 E. 31st STREET 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK ¥☐Widowed 4 ☐ Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

CONTINENTAL CAN

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be multired at angles. Baltimore, Maryland 21215-0036

Physician

Examiner

Funeral

Director

/Medical

10a. State

MD.

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Elementary/Secondary (0-12)

empleted by Funeral Director

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed

Division of Vital Records, P.O. Box 68760,

ŏ	oth		TRUCK I	ORIVER		<u>U.</u>					
Be	17. Father's Name (First, Middle, Last)				ame (First, Middle, Maid	en Sumame)					
0	PHOSTELL BL	ACKWELL		MAZZ	mra praa	725-750 T T					
Ξ,						KWELL					
i))	19a. Informant's Name/Relationship (7			ess (Street and Number or F			Zip Code)				
1	MARTHA EVANS	/ daughter	2427 M	ADISON ST.B	ALTIMORE,	MD. 212	205				
	20a. Method of Disposition		Place of Disposition (I	Vame of	Date 20c.	Location - City or	r Town, State				
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hernovar from Stage / 🗸 🫪 1	RDENS OF	FAITH CEM.	IL 3,2007 BA	LTIMORE	E,MD.				
ļ	21. Seture of Funeral Service Licen	7. Jerues		and Address of Facility IN B. SCRUG			01010				
	23a. Part 1. Enter the disease, or comp	olications that caused the dea	th. Do not enter the m	node of dying, such as cardia	ST. BALT ac or respiratory arrest,	U,MD. Z	Approximate				
	shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	0				Interval Between Onset and Death				
	disease or condition resulting in death)	a Lung	Cance	r							
	resulting in dealth)	Due to (or as a consec	quence of):								
		_									
5	Sequentially list conditions,	b. Due to (or as a consec	quence of).								
by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury										
Kar	that initiated events resulting in death) Last	c. Due to (or as a consec	wanes of								
Û	,	Due to (or as a consec	(uerice or);								
20		d.									
9											
	IF FEMALE:	23c. If yes, outcome of pregn.	ancv			004 Data at 4	Park				
8	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 Ectopic	pregnancy		23d. Date of de Month	Dav Year				
5	1 ☐ Yes 2 ☐ No 9 ☐ Unknown			,							
=											
	Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc	o use contribute t	to the cause of death?				
					1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown				
2000							/\				
1					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of				
					performed:	death?	s 2□ No				
	25. Was case referred to medical			OO Disease I De		10 10	3 2 140				
,	examiner?	Hospital:			eath (Check only one)						
2	1 165 2 100	1 Inpatient 2	ER/Outpatient 3	DOA 4 Nursing	Home 5 Residence	6 ☐Other (Spe	ecify)				
	27. Manper of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Déscribe how in	jury occurred					
	2 Accident investigation		М	1 ☐ Yes 2 ☐ No							
2	3 Suicide 6 Could not be	28e. Place ol Injury - At h	ome, larm, street, fact	ory office	28f. Location (Street	and Number or B	lural Route Number				
	4 Homicide determined	building, etc. (Special	(y)		City or Town, Sta	afe)	ala, ilouto i varibor,				
5											
medical Certification;	29a. Certifier 1 X Cartifying Phy (Check only 2 Medical Exam	ysician: To the best of my kno inar: On the basis of examina	owledge, death occurr	ed at the time, date and place	ce, and due to the cause	(s) and manner a	s stated.				
5	one)	and manner stated.	and and an investigati	on, in my opinion, death occ	dired at the time, date a	ind place, and du	e to the cause(s)				
Ě	29b. Signature and title of certifier			29d. [Date signed (Mon.	th, Day, Year)					
	X	-	-	D 40 21/19) 2	00	07				
				Drage	- 2	- 21-	07				
	30. Name and address of person who d	completed cause of death (Iter	n 23a) (Type, Print)	200 5	/	4					
	youla Mer	apront	MD 2	323 OVI	eans 2	84 · 130	est mis				
y	31. Date filed (Month, Day, Year)	32. Pagistrar's Signa	ature	- 10			2127/1				
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DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day William Daniel Bechill 3:00 AMM March 23, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months 1**⊠**M 2□ F 78 381-22-4662 04/26/1928 MΙ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 217 No Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11505 Rokeby Ave. 20895-United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Higher Education Elementary/Secondary (0-12) College (1-4or 5+) Professor of Social Work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bechill George Elenid Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Ann Bechill/Wife 11505 Rokeby Ave. Kensington, MD 20895-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 3 27 07 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility M00382 Style & Lohuman Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Cardiomyopathy Due to (or as a consequence of): Pneumonia Due to for as a conspoued of Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

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To the Hosp within 24 hor To the Fune completely fi

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The law requires that the death

Box 68760.

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"natural", or items 23a or 28a-f show idical Examiner must be notified at

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filed within 72 hours after death with the Maryland Hygiene.

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event

Baltimore, Maryland 21215-0036

Sequentially list conditions, it are a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24a. Was an autonsv perform 2.20 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 2 No 1 ☐ Yes 27. Manner of Death 1 Natural

1 Inpatient 28a. Date of Injury 5 Pending investigation (Month, Day Year) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one)

29b. Signature and title of certifier

MAR 2 8

29c, License number D27660 29d. Date signed (Month, Day, Year) 23/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alpana Goswami /11119 Rockville Pike Ste G100 Rockville MD 20852 31. Date filed (Month, Day, Year) 2. Registrar's Signature

State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

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			_ For	Department of Health and Ment	tal Hygier	10
			1 - State Registrar	Certificate of Death	Reg. N	
×	Physici		1. Decedent's Name (First, Middle, Last)		ate of Death Month	3. Time of Death
и	/Medic	_	Doris Marie Carroll	Mar		2 2007 4:49 P [™]
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	10	4c. County of Death
		2	1450 Watts Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last b)	Severn irthday) If Under 1 Year If Under 24 Hrs. 8, Di	ate of Birth	Anne Arundel 9. Birthplace (State or Foreign
gle.	Funeral Director		1 M 2X F	Vre Months Days Hours Min. (A	Month, Day, Yea	
A	-		Usual Residence of Decedent		/08/1946	6 Maryland
	yland now at		10a. State 10b. County 10c. City, Tov	wn or Location		10d. Inside City Limits
	a-f st ified	cto	Maryland Anne Arundel S	evern		1 ☐ Yes 2 💢No
	or 28	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	th will		1450 Watts Avenue	21144		J.S.A.
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify \) If Yes, specify Cuban, Mexican, Puerto Rican	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc.
36	afte or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 🗖 No Specify:		Specify: Black
ö	hours tural'	g p	3 ☐ Widowed 4 ☑ Vear or Dates: 15. Decedent's Education 16a	a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
21215-0036	n 72 i "na'	ete	(Specify only highest grade completed)	(Give kind of work done during most of working lile. DO NOT use retired)		,
7	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Mail Clerk	U.S	S. Post Office
0	Hyg Other ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs	st, Middle, Maid	en Surname)
Maryland	lid be lental rked rked	To B	Milton Burley	Betty Art	is	
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print)	b. Mailing Address (Street and Number or Rural Rou	ute Number, Cit	
Ξ	and 2			509 Pinewild Rd., Seven		
ore	of He of Herr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of ery, crematory or other place)		Location - City or Town, State
altimore,	Pag nent ant: I		4 Donation 5 Other (Specify) King	Mem. Park Ceme. 03/31/20		ltimore, Maryland
alt	permit. Departr Imports any inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility The De	errick (C. Jones F/H, P.A.
<u> </u>	9 9 E 9		D. C. &	4611 Park Hgts. Ave.,		
L			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	. // . /	piratory arrest,	Approximate Interval Between Onset and Death
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<i>}</i>	/Medical Examiner		Due to (or as a consequence	: of):		
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	ed set	xaminer	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury	. 6().		
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68760	ficate phys s the	gic	d			
×	certifu nding use a	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery
. Box	death e atte	icial	in the past 12 months? 1 Ves 2 No.	th 3 □ Ectopic pregnancy 5 □ Other (specify)		Month Day Year
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ري ص	s tha	by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	V/	o use contribute to the cause of death?
Records,	w requires to been signed should be a	pa	Thin Myajasi		1 Yes	2 No 3 Probably 4 Unknown
ပ္က	aw re Is bee	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ž	The law	ШО			performed	? death? No 1 □ Yes 2 □ No
Viita	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chi	eck only one)	
>	Attending Physician: r death. ector: After this certifica by the funeral director, I	To E	1 Yes 2 No Hospital: 1 Inpatient 2 ER/O		5 Residence	6 □Other (Specify)
0	ding Pi J. After ti funeral	E	27. Manner of Death 1. Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b.	Injury Work?	Déscribe how in	njury occurred
sio	eath. or: A	catio	Accident investigation	M 1 Yes 2 No		
Division or	or At fler di pirect n by 1	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, 1 building, etc. (Specify)	arm, street, factory, office	ocation (Street City or Town, St	a <i>nd Number or Rural Route Number,</i> ate)
	oltal curs af		One Continue 11 Continue Physician 7 the heat of my leader	ne death occurred at the time date and place and	due to the course	a(s) and manner as stated
	Hospital or Attend 24 hours after deatt Funeral Director: stely filled in by the	Medical	29a. Certifier (Check only one) (Check only one) (Check only one)			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Mec	29b. Signature and title of certifier.	29c. License number	29d. l	Date signed (Month, Day, Year)
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Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month Day, Year) MAR 2 8 2007

			1 - For State Ragistrar	State of	Marylar	•	artment of H			iene ag. No. 2	07	09570
			1. Decedent's Name (First, Middle, L.	ast)					2. Date of Deat	th		3. Time of Death
	Physicia		Craig		M		Carter		Month March	20, 200	Year 7	8:24 PM
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and num	ber)		4b. City, Town, or	Location of Death		4c. County		
			501 Hurtt Place				Fort Wa	shington		Prince	Geo	rges
	Funeral				. Age (In yrs.			If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	Coun	lace (State or Foreign
	Director		100 30 0233	1 M 2 □ F	43	Yrs.	Michial Days		May 14,	1963	Peni	nsylvania
	w w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				1	0d. Inside City Limits
	Maryli Pho ed a	ō	MD Prince G	ooman ! s								1 ☐ Yes 2 No
	the N	Director	10e. Street and Number	eorge s	FL	. Wash	10f. Zip Code		1	Og. Citizen of W	/hat Coun	trv?
:	With Ba or	0	501 Hurtt Place				2074	/.		USA		-,-
	Jeath The 20	Funeral	11. Marital Status	12. Was Deced	lent Eyer in U	.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		e - Americ	an Indian,
0	be filed within 72 hours after death with the Maryland nat Hygiene. Ad other then "naturel", or items 23s or 28s-f show event, the Madical Examinar must be notified at	by Fur	1 ☐ Never Married 2 [X Married	1 XYes 2	3 ³ 714/	87	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puerto Specify:	Rican, etc.)		k, White,	
Ź,	hours ture!		3 ☐ Widowed 4 ☐ Divorced	Year or Dai	les:	16a Dasa	dent's Usual Occupa	ntion		16b. Kind of Bu		
<u>ה</u>	in 72	Completed	(Specify only highest g	ade completed)		(Give	kind of work done of DO NOT use retired	during most of work	ring	TOD. KING OF BU	311105571110	lustry
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0	id be fental ked ic ev	To B	Lloyd Carter					Barbara	Scott			
<u>ק</u>	Should No Man	_	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a			City or Town,	State, Zip	Code)
2	alth alth 27 in 27 in er tre		Maria Carter - W	ife			501 Hurtt	Place Ft	. Washi	ngton, l	MD 2	20744
2	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	TRomoval from S		Place of Disponentery, crea	sition (Name of matory or other plac	(8)	Date	20c. Location ·	City or To	wn, State
	Page ment ant: fi ury o		4 Donation 5 Other (Spec			mily C	emetery	3/24/	/07	Middles	ex,	7A
Dall	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if fine 721 is marked other then "naturel; or itema 23a or 28a-1 ehow eny injury or other treumatic event, the Martical Examiner must be notified at once.		21. Signature of Funeral Service Lice	end C	2		2. Name and Address 632 Louis	-	edmond F er Mem H			fords, VA
			23a. Pagri. Enjer the disease, or cor spock, or near failure. List only	nplications that ca	used the deat	h. Do not en	er the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between
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	icate be executed physicien end s the burial-transit	Examiner	that initiated events	c								
ຼັ	sien e	EX	resulting in death) Last	Due to (o	r as a conseq	uence of):						
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cords,	en sig	ed							1 □ Y€	os 2□No	3 Prob	ably 4 □Unknown
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	ertific ector,	Be	25. Was case reterred to medical examiner?					26. Place of Deat	h (Check only on	θ)		
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5	th. : After	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		, Day Year)	28b. Time o Injury	Work	yat k? Yes 2 □ No	28d. Describe ho	w injury occurr	be	
	Atter r dee ector by the	#Ca	3 Suicide 6 Could not determined	286. Place 0	of Injury - At h	ome, farm, sti	eet, factory, office		28f. Location (St		er or Rura	l Route Number,
5	tal or rs afte al Dir ed in	Cert	4 Notthicide	building	g, etc. (Specif	Y)			City or Town	i, State)		
	to the hospital or Attending Physicien: The law fequires that the death centric within 24 hours after death. After this certificate has been signed by the attending to the Fundral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deteched for use as	edical	29a. Certifier (Check only one) Certifying P 2 Medicat Example 1	hysician: To the b miner: On the bas and manne	sis of examina	wledge, deat ition and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and mar ate and place, a	nner as st and due to	ated. the cause(s)
,	within To the comp	ž	29b. Signature and title of certifier	/_		Al	29c. License	e number	2	9d. Date signed	(Month, i	Day, Year)
•	9		How.	-or	_ /		000)6417	8	03/2	2/2	2007
10			30. Name and address of person who	completed cause	of death (Item	n 23a) (Type,	Print)	treet.	Washi	w tres	D	20717
	Sta	te	31. Date filed (Month, Day, Year)	32 Re	gistrar's Signa	ature	rving S	1000	V-0.3711	1	/	- 2010
	Registr	ar	MAR 2 8 2	007	war &	7. An	na!			_		

DHMH 17 Rev 1/2001

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×	Physicia	_	Decedent's Name (First, Middle, La Mar	ie Bert	ha Coo	k				2. Date of Dea Month March	th Day 27	2007	3. Time o	
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and nu	mber)		4b. City, Town, or Location of Death				4c. Co	unty of Death		A •
			Glen Burnie Hea			s. last birthday)	Glen Burnie				Anne Arunde1 of Birth 9. Birthplace (State or Foreign			or Foreign
×	Funeral Director			_M 2 _X F	83				ours Min.	(Month, Day	Year) 1923	Cour	yland	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation					1	Od. Inside C	ity Limits
	e Man Ba-f eh	Director		Arundel	L	Baltimo					<u>.</u>			2 🕱 No
	death with the Marylan oms 23a or 28a-f chow ir must be trylling at	i Dire	10e. Street and Number 498 Matthews A	venue			10f. Zip Co	ode 21225	5	1		of What Cour	ntry?	
	ems 2;	Funeral	11. Marital Status	12. Was Dec	edent Ever in orces?	U.S. 13.	Was Deceden	nt of Hispan Cuban, Me	ic Origin? (Spo exican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,		
39	be filed within 72 hours atter death with the Maryland half Hygiene. Ad other then "nature", or items 23e or 28e-f ehow event, ite Madical Examinar must be notified.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 [] Yes If Yes, Gi Year or [2 XNo ve ates:		1⊡Yes 2Ū	No Sp	ecify:		Sp	ecify: Whi	.te	
21215-0036	72 hor	Completed	15. Decedent's E (Specify only highest gra		-	(Give	dent's Usual C	done during	most of work	ing	16b. Kind	of Business/In	dustry	
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D L	12 should be filed within 72 hour hand Maharal Hygiene. "naturel ? is marked other then "naturel traumatic event, tra Mudical Es	Be	17. Father's Name (First, Middle, Last Samue1	_				18.1		e (First, Middle, Mabel No		mame)		
Maryland	should but and Ment smarked umatic e	ဥ	19a. Informant's Name/Relationship (Number or Rura	al Route Number	r, City or To		Code)	
	is 1 and 2 should of Health and Mer frem 27 is marke other traumatic			Son ₁ -E						, Maine	-			•
altimore,	Pages 1 nent of H int: if ite iry or of		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		State 1	Place of Dispo cemetery, crei ayview			1	/2007		ion-City or To imore,		and
Baltii	permit. Pages Department of Important: if the ony injury or of once.		21. Signature 1 Funeral Service Lice			-			Facility Go Highwa	nce Fund y Balt:				
			23a. Part1. Enter the disease, or som shock, or heart failure. List only										Approxima Interval Be	ite etween
A.	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Cong	eitue	Heart	Fact	w	2				Onset and	Death
	Examiner		Sequentially list conditions,	· Coronory artery disease										
b	ted sit	niner	cause. Enter Underlying Cause (Disease or injury	Due to	(or as a cons	equence (bf):								
760, /	te be executed ysician and te burial-transit	Examin	that initiated events resulting in death) Last	c. Due to	(or as a conse	equence of):								
	eta y et	edical		d										
XO	death certitics e attending ph ed tor use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of preg		∃Ectopic preg	gnancy			230	I. Date of delive	ery Day	Year
O. B	the dea y the att ched to	ysici	in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown		nant at time of		Other (spec					MOHIII	Day	real
ds, P.	The law requires that the de ste has been signed by the page 2 should be detached	5	Part II. Other significant conditions	contributing to d	leath but not r	esulting in the u	nderlying cau	ise given in	Part I.		bacco use	contribute to t		death? Unknown
Records,	# VI OI	Completed								24a. Was a	in 2	24b. Were auto	psy findings	available
a R	Physician: The la this certificate ha ral director, page 2									perfor	med? 2000 No	death? 1 ☐ Yes	2 No	
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 South Property 1 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Des										Other (Specia	(y)			
n O	ling Ph Atter th uneral		27. Manner of De th 1 Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury	f 280	c. Injury at Work?		28d. Describe h				
Division of Vital	il or Attending Pater death. I Director: Atter to in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Plac	e of Injury - At ling, etc. (Spe	home, farm, st			2 1140	28f. Location (S City or Tow	treet and N n, State)	lumber or Rura	al Route Nui	nber,
	Hospita 4 hours Funera ely fille	edical Ce	29a. Certifier 1 Certifying Pl	miner: On the	pasis of exami	nowledge, deat nation and/or in	h occurred at vestigation, in	the time, da	ate and place, n, death occur	and due to the c	ause(s) an	d manner as s	taled.	(s)
	To the within 2 To the complet	Med	29b. Signature and title of contifier	ano mai	nner stated.			License nun	mber		29d. Date s	igned (Month,	Day, Year)	
			1 20	1	MD			1589	58		5/2	1/07	, 	
		1	30. Name and address of person who	completed cau	se of death (II	em 23a) (Type,	Print)				1	1		
	10		Dufreet Sine	L Sie	Registrar's Sig	108 G	ain /	HERR	way S	w a	Cen 1	Burnie	MD	21061

			For State Registrar	State of Maryla	-	artment of Hortificate of L			ene 0 0 7	09672
	Physici /Medic		Decedent's Name (First, Middle, Last	Virginia E.	Cloud			2. Date of Death Month March	24 2007	3. Time of Death 5:00 P. M
	Examir		4a. Facility Name (If not institution, give Marley Neck Hea			4b. City, Town, or Glen B			4c. County of Death	
	Funeral Director		5. Social Security Number 6. Se		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 20	9. Birth	place (State or Foreign Intry) aryland
	land w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	e Mary	ctor	Maryland Baltin	nore	Baltimo	re				1 ☐ Yes 2 🙀 No
	th with th	Funeral Director	10e. Street and Number 2738 Aldenwood	Road		10f. Zip Code 212	27	10	U.S.A.	intry?
980	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Examinat must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🙀 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
15-0	"natur	leted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	urina most of worki	ing 1	6b. Kind of Business/li	ndustry
21215-0036	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) 5th	College (1-4or 5+)	_	nspector			Sweetheart	Paper Co.
land	ould be fil Mental H arked ott atic even	To Be	17. Father's Name (First, Middle, Last) George	e M. Cord			18. Mother's Name	Hampton	faiden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any hojury or other treumatic event, the Madical Exertirer must be notified at order.	-	19a. Informant's Name/Relationship (T) James M. Cloud	, , ,		ng Address (Street a			City or Town, State, Zi , Maryland	
			20a. Method of Disposition 1X Burial 2 □ Femation 3 □ I	Removal from State	. Place of Dispo cemetery, crei	osition (Name of matory or other place	·)	Date 2	20c. Location - City or T	own, State
Baltimore,		1	* 4 □ Donation S □ Other (Specify, 21. Signature of Fun and Service Linears			lge Mem. P 2. Name and Addres:			lkridge, Ma ral Service	
e e	20168		113	i and the state of	· · · · · · · · · · · · · · · · · · ·	01 Ritchi	e Highway	, Baltin	nore, Maryl	and 21225
	Physician /Medical Examiner		23a. P.frt1. Enter the disease, or compositions shock, or heart failures. List only of immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	ARY	ART	ERY	DISE	ENSION	Interval Between Construction and Fazing S
68760,	icate be executed physicien and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
Box	ath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	d	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	very Day Year
rds, P.O	quires that the de n signed by the a lid be detached t	by	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
al Records,		Completed						24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred medical examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	26. Place of Death		nce 6 Other (Spec	(hr)
on of	Attending Physrdeath. coeter: After this by the funeral di		27. Mann of Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	-	f 28c. Injury Work	-	28d. Describe hov		.,,,
Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,
	e Hospite 24 hours e Funere tetely fille	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kiner: On the basis of exami and manner stated.	nowledge, death nation and/or in	h occurred at the time vestigation, in my op	e, date and place, a inion, death occurr	and due to the car ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
)	To th within To th comp	Me	29b. Signature and little of certifier	ngl m		29c. License	1416 () N	d. Date signed (Month) ARCH 25	7 2007
	M		30. Name and address of person who co	ompleted cause of death (it	em 23a) (Type,	Prin 5410 -	ARIT	CHIE	HIGH	NAY)
F	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8 2	32. Registrar's Sig	nature		B	ACTIM	TORE, M	19.21225

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 23 tate of Manual Amend Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Month **Physician** 11.25 PM MARCH Jesse Steve Cowger 2607 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** affinere washington medical Cente Hnne Hunder . Age (In yrs. 8. Date of Birth (Month, Day, Yout. 10, 9. Birthplace (State or Foreign Country) West Virginia ecurity Number If Under 24 Hrs. **Funeral** . 1944 Months Days Hours Min 1 M 2 □ F 62 218 42 1966 Oct. Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at N/A Baltimore Director Maryland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4102 Orchard Avenue 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after Hygiene. 1 XYes 2 No
If Yes, Give
Year or Dates: Viet Nam 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hyglene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Carpenter McLean Contractors 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Smith Edward Cowger 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Michele Moyers / Daughter 2717 Yarnall Road Baltimore, Maryland 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 3/19/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland ^{22. Name and Address of Facility} Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Fur eral Service Licens 23a. Part1. Enter the disease, or complications that caused the demander of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FALLS **Physician** 4 aluzz /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been significated by page 2 should by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 10 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident neral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 24 and manner stated. the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45149 March 13 2007

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, MAR 2 8

34MAG

Glen Burrie MD

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Physician /Medical Examiner The law requires that the death certificate be executed the burial-tran and attending physician for use as the buria Division or Vital Records, P.O. Box 68760

Physician

/Medical

Director

Funeral

þ

Completed

Be

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Examiner

Funeral

Director

27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

al Hygiene.

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Department of important: If it any injury or conce.

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Baltimore, Maryland 21215-0036

Examiner Physician/Medical 3 Be Certification: To safter dec.

signed by the a

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funeral director,

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Medical

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To the Funeral |
completely filled

or Attending Physician:

בו דע	resulting in death) Last
completed by raily sicial innedical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant con
2	Dementia
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Ú	25. Was case referred to me

29b. Signatore and title of certifier

MAR 2 8

resulting in death) Last	Due to (or as a consequen
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown
Part II. Other significant conditions of Dementia	contributing to death but not resultin
25. Was case referred to medical examiner? 1 ☐ Yes 2돐 No	Hospital: 1 ☐ Inpatient 2 ☐ ER
27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigatio	28a. Date of Injury (Month, Day Year)

Pai	rt II. Other significant conditions	Sittibuting to death but not resulting in the dildenying cause given in a art i.	2001 010 100000 000 0011110010 10 1110
	Dementia		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unkno
			24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings availa prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No
25	. Was case referred to medical	26. Place of Death (C	Check only one)
	examiner? 1 ☐ Yes 2 K No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA Other: 4 Nursing Home	5 ☐ Residence 6 🖾 Other (Specify) ASS. Livi
27	. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	d. Describe how injury occurred
	3 Suicide 6 Could not determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)
29	Pa. Certifier (Check only one) 1 ☑ Certifying F 2 ☐ Medical Example 1	ysician: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

29c. License number

D20367

29d. Date signed (Month. Dav. Year)

March 26, 2007

10+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

1396 Piccard Drive, Rockville, Maryland 20850 P. Kalman, M.D. 31. Date filed (Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Frances N. Dobrodey 23 2007 8:15 A. March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Anne Arundel 205 Greenland Beach Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Oay, Year) Feb. 2, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🕱 F 79 1928 214 22 7343 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 27 is marked other than "natural", or Items 23e or 28e-f show treumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 🛣 No Maryland Glen Burnie Anne Arundel Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 7627 Baltimore & Annapolis Blvd. 21060 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentai Hygiene. Important: If Item 27 le marked other than "natural", or Item any injury or other treumatic event, the Medical Examana 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Andrew J. Dolan Fannie A. Graves 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 Greenland Beach Road Baltimore, Maryland 21226 Mary Madelin King / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/27/2007 Glen Burnie, Maryland Glen Haven Mem. Park 🖯 ¹ 4 □ Donation 5 □ Other (Specify) ²² Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Licensee 4001 Ritchie Highway 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Approximate Interval Between Onset and Death ations that caused the death. e cause on each line. or complie Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Day Un **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner signed by the attending physician and does detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 100 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 10465 2 No 3 Probably 4 Unknown cate has been significate has been significated by page 2 should be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No rmed? certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 1 Yes 4 Nursing Home 5 Residence 6 Dother (Specify) S. STERS Hom 2 ER/Outpatient 3 DOA 2 100 1 Inpatient 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 1 🕒 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D death (Item 23a) (Type, Print) tror Madam 31. Date filed (Month, Day, Year) MAR 2 8 gistrar's Signature 32. State 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Patricia Kathleen Dietrich 12:20 PM March 23, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Rethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/10/1946 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1□M 2KIF Days 60 347-38-0209 Director NY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits show the Medical Examiner must be notified at 1 □Yes 2 No Director MD Montgomery Cabin John 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6530 75th St. or items 23a 20818-IISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 234 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-003 "natural", White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Restaurant & retail than, Elementary/Secondary (0-12) College (1-4or 5+) **Business Woman** Pages 1 and 2 should be filed verent of Health and Mental Hygicient: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Hughes Dietrich Sylvia Sue Sommers ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robinwyn D. Lewis/Sister 6530 75th St. Cabin John, MD 20818-20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot Mar 28 Chesapeake Crematory Beltsville, Maryland 4 Donation 5 Dother (Specify) 2007 21. Signature of Funeral Service Licensee Name and Address of Facility
Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage

Due to (or as a consequence of disease or condition resulting in death) /Medical Examiner Tepatocellula-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a consequence of) death certificate be executed Due to (or as a consequence of) Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Year 4□Pregnant at time of death 5 Other (specify) detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Was ar. autopsy performed? Ves 25 No 24a. Was an page 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient မ 1 🔲 Yes 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the Hospital
within 24 hours a
To the Funeral I
completely filled

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
AAR 2 8 2

Matthew



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	For	State o	of Maryland / Depa	rtment of Health and Mental Hygiene					20.0	-7 "
-	State Registrar		Ce	Certificate of Death				1	096	1.
I. Decedent's Name (First, Middle, Last)						2. Date of Death	Day Year		3. Time of Death	
	Ruth	W.	Evans			March 14	, 2007		9:51	Αľ
a. F	acility Name (If not institution	n, give street and nu	ımber)	4b. City, Town, or	Location of Death		4c. County o	of Death		
U	niversity of	Maryland	Medical Cente	r Baltim						
. Sc	ocial Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	(225)		ace (State of	r Foreig
1	90-30-5338	1 ☐ M 2 X ☐ F	67 Yrs.	Months Days	Hours Min.	(Month, Day,) May 10,	1939	Penn	sylvar	nia

Funeral Director

'natural', or items 23a or 28a-f show dical Examiner must be notified at

filed within 72 hours after death with the Maryland Hygiene. other Pages 1 and 2 should be fill ment of Health and Mental H ant: If Item 27 Is marked out permit. Pages 1
Department of F
Important: If Ite
any Injury or ot

Maryland 21215-0036

Baltimore,

Physician /Medical Examiner

sician and burial-tran the signed by the a After or At.

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Completed

Be

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Certification:

Medical

The law requires that the death certificate be executed

Physician:

Box 68760.

P.O.

Division or Vital Records, or Attending To the Hospital o within 24 hours aft To the Funeral Di State

/Medical Examiner 190-30-5338 May 10, 1939 Usual Residence of Decedent 10c. City, Town or Location 10b. County Director Maryland Caroline Preston 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21655 6155 Bethlehem Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Memorial Hospital College (1-4or 5+) Elementary/Secondary (0-12) Central Supply Clerk 12 in Easton Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna G. Willman Oliver Roy Wilson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6155 Bethlehem Rd., Preston, MD 21655 (Husband) Francis C. Evans 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3/17/07 1 N Burial 2 Cremation 3 Removal from State Belsano, PA United Brethren Cemetery 5 Other (Specify) 4 Donation 22. Name and Address of Facility Askew-Houser Funeral Home, 21. Signature of Funeral Service Licensee 1310 Shoemaker St., Nanty Glo, PA 15943 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial Infarction disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical

IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

4□Pregnant at time of death 9□Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

6 Hours

10d. Inside City Limits

White

1 ☐ Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Apneic Episode

Hypoxic Brain Injury

24a. Was an autopsy performed?
Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

5 Pending investigation 6 Could not be determined

Hospital: 1 X Inpatient 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

17514

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

March 14, 2007

(Check only one) and manner stated 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

1☐ Yes

28d. Describe how injury occurred

Christina Bennett, MD 31. Date filed (Month, Day, Year)

MAR 2 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature marke

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

826 S. East Ave., Baltimore, MD 21224

			1 - For State Amend #5, perFh,	State of Ma G866, 4/18/	י חדדו בי	partment of H ertificate of		Mental Hygie Reg.	EUUI	09678	
			Decedent's Name (First, Middle, Last))				2. Date of Death Month	Day Year	3. Time of Death	
	Physici /Medic		WILLIAM	FREDERICK	H	RUEH		MARCH 22,		11:30 P ^M	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deati				
			HOLY CROSS HEHAB			SILVER	SPRING_		MONTGOMI		
	Funeral		5. Social Security Number 6. Sec	*	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Month Day V	9. Bir	thplace (State or Foreign ountry)	
	Director		347-24- 9073	M 2UF 9	1 Yrs.			JUNE 11,	1915 NEW	JERSEY	
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0	r House	Fur	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No	∘ wwii	If Yes, specify Cub		o Hican, etc.)	Black, Whit		
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E			CONGESTIVE HEART FAILURE						YEARS		
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ם ב		n: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time		y at	28d. Describe how	injury occurred		
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IVIX	irect irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, face building, etc. (Specify)				factory, office 28f. Location (Street and Number City or Town, State)			ural Route Number,	
בַּ	orei D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
H	24 ho Fun etely f	edical			examination and/or			irred at the time, date			
Ę.	To th compl	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon						th. Day, Year)		
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Ì	2		30. Name and address of person who co				T A 11000	MD 20707			
•			LALITHA TADIKONDA,	M.D. 13	952 BALTI	MURE AVE.	, LAUREL	, MD 20/0/			
	Sta Registr		MAR 2 8 20	07 Descention	r's Signature	caree					

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 24 2007 Year **Physician** 5:26 A M Elizabeth Feaga /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson 7. Age (In yrs. last birthday). If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □XF Months Days Hours 218-26-0661 Aug 2 1929 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State al Hygiene.
I Hygiene.
I other then "natural", or items 23a or 28a-f ehow
vent, the Medical Examinat must be notified at Glen Arm **Baltimore** MD 1 ☐ Yes 2 ☐ No Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Suite 142 USA 11630 Glen Arm Rd. 21057 Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21☑ No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) domestic homemaker or other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H Nani A. Thurman William S. Ledbetter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11630 Glen Arm Rd. Suite 142, Glen Arm, MD 21057 Bernard Feaga (spouse) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if any injury or once. Crest Lawn Memorial 3-27-07 Marriottsville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee M00769 P.O. Box 195 Sykesville, MD 21784 Drian 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) RAVENTRICULAR JACHY CARDIT **Physician** /Medical Due to (or as a consequence of): CARDIAL **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien end for use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed ON Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2018 INE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 212 No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural efter death. м 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28J. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours e To the Funeral C Medical 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of centre 29c. License namber MARAGORAL NAME ROLLING STORY 5 2. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 2 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARY A. FARUOL 200 narch /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner osedale If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) last birthday Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 ☐ F Yrs. Mary land 68 Director 212-36-2913 16.1938 Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 28a-f show ns 23a or 28a-f shov must be notified at 1 TYes 2XXNo Director Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 3936 New Section Rd. **USA** Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or items 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married White 1 ☐ Yes 2 🖾 No Specify Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced "naturai". Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working lite. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) 12 yrs. Administrative Assistant Banking is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othr any injury or other traumatic event once. Be Marie Spilman Frank Meurer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Md. 21220 Dennis M. Faruol (Husband) 3936 New Section Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XIX Burial 2 ☐ Cremation 3 ☐ Removal from State 3-26-07 Baltimore, Md. Immanuel L.C. Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee Lassahn Funeral Home ass who 7401 Belair Rd. Baltimore, md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of) Examine Division or Vital Records, P.O. Box 68760, を Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by SVOOL 2 No 3 Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be execut**e**d Director: Funeral Dire within 24

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

To the Fune completely f 70

Registrar

9000 32. Resistrar's Signature

31. Date filed (Month, Day,

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

X	
P.O. Box 68760,	
cords, P.O. E	
Division or Vital Records,	
DIVISION	

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Dhusis	ia.	Decedent's Name (First, Middle, Last)		timoato or	Douin	2. Date of D		4	3. Time of Death
Physic /Med	ical	Charles Gordon I	aro			March		2007	5:45 A M
Exami	ner	4a. Facility Name (If not institution, give street and number) VA Maryland Health Care System			or Location of Death		4c. Count	ty of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yr	rs. last birthday)	Perry P If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth		lace (State or Foreign
Director		219 54 4174 1 M 2 F 56 Usual Residence of Decedent	Yrs.				22,1950	Mar	y1and
larylan show	۲		City, Town or Lo		-			1	0d. Inside City Limits
r 28a-f notifie	Director	10e. Street and Number	Baltimo	re 10f. Zip Code			10g. Citizen of	What Cour	1 ☐ Yes 2 🛣 No
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tter de: • items Iner m	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ No	U.S. 13. V	Was Decedent of F f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14. Ra Bla	ce - America ck, White,	
ours al	þ	If Yes, Give	et Nam	I∐Yes 2. XINo	Specify:		Speci	y: Whi	te
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l be file	Be	17. Father's Name (<i>First, Middle, Last</i>) Salvadore Faro			18. Mother's Nam	,		me)	
should ind Me i mark umatic	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Rui	na Wrig		State Zin	Code)
and 2 ealth a m 27 Is		Melissa Faro / Daughter	3702	McDowe11	Lane Ba	ltimore	e, Maryl	and 2	1227
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1	Place of Dispos cemetery, cren	sition (Name of natory or other place	Cem. 3/26	Date /2007	20c. Location	•	•
permit. P Departme Importan any injuri		4 Donation 5 Other (Specify) 1711 21. Signature of Funeral Service Licensee		. Name and Addre			neral Se		, Maryland
a E E		- Jecome Joannevery			ie nignwa	у ватт	imore,	Mary1	and 21225
Dharfalas		23a. Part1. Enter the disease of complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final			ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events	Partyling or injury tts c						
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leath certific attending p for use as t	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fe		Ectopic pregnancy	,		23d. Da	ate of deliver	ry
at the des by the at tached fo	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown		Other (specify)			M	onth I	Day Year
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	Be Cc	25. Was case referred to medical examiner?			26. Place of Deatl	1□ Yes	2 No	1 ☐ Yes	2X No
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I or Attending Physician: after death. Director: After this certification by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At he building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Numb	per or Rural	Route Number,
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To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	one) and manner stated.	ation and/or inv	estigation, in my o	pinion, death occur	red at the time,	date and place,	and due to	the cause(s)
with Volume	2	29b. Signature and title of certifier	1110	29c. License			29d. Date signe		Jay, Year)
IXO		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, P	D4280			3/21/0	17	
7		Thomas Biondo, M.D. VA Maryla 31. Date filed (Month, Day, Year) 32. Registrar's Sign	and Heal	th Care	System F	erry Po	oint, MI	219	02
Sta Registr		31. Date filed (Month, Day, Year) . 32. Registrar's Sign		sells)					
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State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 11:44 AM 1. Decedent's Name (First, Middle, Last) March 25 pay 2007 Year Marcia Carolyn Friedman Physician /Medical 4c. County of Death
Montgomery 4a. Facility Name (If not institution, give street and number)

Maplewood Park Place 4b. City, Town, or Location of Death **Bethesda Examiner** If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign N Country) 5. Social Security Number 081-01-8338 7. Age (grs. last birthday) 8. Date of Birth 05/304/1916 **Funeral** Days 1 □ M 2 F Yrs. Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at MD Montgomery Bethesda 1 Yes 2 No Direct 10f. Zip Code 20814-10g. Citizen of What Country?
United States 10e. Street and Number 23a or 9707 Old Georgetown Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or iteme 11. Marital Status hours after 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation Own Home 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker n and Mental Hygier Is marked other t 18. Mother's Name (First, Middle, Maiden Surname)
Anna Stoloff 17. Father's Name (First, Middle, Last)
Samuel Rabinowitz Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked eny injury or other traumatic evonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Mickey Ct. Huntington Station, NY 11746-19a Informant's Name/Relationship (Type, Print) Ellen Hartley/Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Beltsville, Maryland 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Rappe Funerab Facilifremation Services 21. Signature of Funeral Service Licensee 933 Gist Ave. Silver Spring, Maryland 20910mo1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTUE LUNG DISEASE Physician CHRONIC SAGE END /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit Due to (or as a consequence of): 68760 Physician/Medical Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗌 Yes 2**X** No 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) After thi funeral 28c. tnjury at Work? 28b. Time of 28d. Describe how intury occurred 27. Manner of Death Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide or A after 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D35791 0 30. Name and address of person who completed cause of death (Item 31) (Type, Print) 9801 GEORGA AVE, SUITE 227, S SILVER SPRING, HD 20902 GEORGIA AVE, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Elizabeth Ford 26, 5:30 A. M March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 22, 19 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🕅 F 579-44-8383 72 1934 North Dakota Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Cold Spring Court 20854 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Torger Oswald Kraabel Charlotte Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis J. Ford / Husband 12 Cold Spring Ct., Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 30. 1 Burial 2 ☐ Cremation St. Gabriel's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee ROBERT A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the dis lase, o shock, or heart failur complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myelodys Musi (Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate caus. End of unity gray (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner Examine be executed attending physician and for use as the burial-tran

Physician

/Medical

Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f shovidical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or a may highly or other traumatic event, the Medical Examiner must be none.

Baltimore, Maryland 21215-0036

Box 68760,

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Records, P.

Division or Vital

Directo

Funeral

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Completed

Be

the Maryland

Be Completed by Physician/Medical Certification: To

	d							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectop	ic pregnancy (specify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions of	ntributing to death but not re	sulting in the underlyin	ng cause given in Part I.		co use contribute to the cause of death?			
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27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	nome, farm, street, fac ify)	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death occur ation and/or investiga	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)			
29b. Signature and title of certifier	_		29c. License number	29d.	Date signed (Month, Day, Year)			
MA (und	mil		53177	in	12×c4 26, 2007			
30. Name and address of person who c	mpleted cause of death (Itel	m 23a) (Type, Print)	9707 MOC	LICAL COM	Ton Day			

State Registrar

Medical

31. Date filed (Month, Day, Year)

MAR 2 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jessie H Gladkowski March 25 2007 1:30 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign November 24 1927 Baltimore, Maryland Months 1 ☐ M 2 ☐ F 214 24 8922 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Marvland Baltimore 1 ☐ Yes 2 ☐ No Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3106 Putty Hill Avenue 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Terminal Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Stanislaus Groncki Anna Klemintine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah D Wells (Daughter) 4049 Cowpass Run Lane Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery March 29 2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Breast Tal Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) W& SA C

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

10a. State

Funeral

Director

and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene.

f Health and Menta Item 27 is marked

permit. Pages Department of I Important: If it any injury or o

Maryland 21215-0036

ed other than "natural", or items 23a or 28a-f sh event, the Medical Examiner must be notified

Box 68760,

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Division or Vital

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Certification:	

1 ☐ Yes 20 No

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 ☐ Homicide

29a. Certifier

12

State Registrar

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number 58203

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. March 26 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), N. Charles St TONSON NO 21204 w AMUN J. CHMUES 6701

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year)

32 Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last Year Physician breenawalt March 2007 22 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner imor N/A bor If Under 24 Hrs. Hours Min. Under 1 Year 8. Date of Birth April Day, Year) April 19,1939 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months 1 X M 2 □ F Pennsylvania 67 190 30 9360 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Glen Burnie Director Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 102 N. Crain Highway Apt. 875 21061 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Narried White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: If Yes, Give Year or Dates: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) 12th College (1-4or 5+) marked other than Campus Police Security Department of Health and Mental Hy, Important: If Item 27 Is marked other any Injury or other the second any Injury or other the second in the second injury or other the second injury Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore Clair Greenawalt Hazel Delrae Harclerode ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 102 N. Crain Highway Apt. 875 Glen Burnie, MD 21061 Shirley Greenawalt / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 3/26/2007 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Serviçe License Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 231. Part1. Enter the disease, or can shock, or heart failure. Liv only ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): meumonia Examiner ahon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year Dav in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 No ed by the detached 9 ☐ Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð should be 2□ No 3 ☐ Probably 1 ☐ Yes Completed ension 24a. Was an autopsy performed? res 2 No certificate 90U 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes Impatient Certification: To 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) atural 5 Pending investigation n 24 hours after death. ne Funeral Director: Af oletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the complet

State Registrar

31. Date filed (Month, Day, Year) MAR 2 8

29b. Signature and title of certifier

Hanovar Street 32. Poistrar's Signature

who completed cause of death (Item 23a) (Type, Print)

2007

Almas Knevani

29d. Date signed (Month, Day, Year)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #20b Per FH C865 3/28/69 rtificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** March 4:59 PM 25, Ihomas 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore
If Under 1 Year If Under 24 Hrs. Medica Baltimore enter 5. Social Security Number 8. Date of Birth (Month, Day, 1933 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1**X**M 2□ F 239-40-8184 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b, County 10d. Inside City Limits Show other treumatic event, the Medical Examinar must be notified at Baltimore MD1 Yes 2 □ No Director 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a or 21229 us A Nationa death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🐪 No Specify: Specify: ģ Black 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Importent: If item 27 is marked other than ' College (1-4or 5+) river Irans 0 Maiden Sumame) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Katie inomas sause Informant's Name/Relationship 19b. Mailing Address (Street and Number or ıral Route Number, 22 Koaches Mar Date 20b. Place of Disposition (Name of cemetery, crematory or either p 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ö 4 ☐ Donation 5 ☐ Other (Specify) 21. Singure of Funeral Service 22 Vacce and Address of Facility Gree any in 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto, mD 21229 Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Jastraintestina disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown cate hes been signed by I page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Multiple Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate 1 Yes 2 No To the Hospitel or Attending Physicien: After this certification funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after oeave.
To the Funeral Director: f investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 134849 March 25,2007 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shillingtord South Greene Street 31. Date filed-(Month, Day, Year) 2. Registrar's Signature State

Registrar

MAR 2 8 2007

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	he att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d		Other (specify)			Moriti	Day Year
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		1 - For State Registrar	State of Maryla	and / Dep		Health and		_	09688
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Year	3. Time of Death
Physi /Med		Sr. Mary Gemma	a Hackett				03	21 2007	11:03p M
Exam		4a. Fecility Name (If not institution, give s	street and number)		4b. City, Town,	or Location of De	eath	4c. County of Deat	
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Funera Directo	_	5. Social Security Number 6. Sex 215 01 7346	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birtl (Month, Day Dec. 1,	9. Birth (Year) 9. Birth (Co 1911 Ma:	hplece (State or Foreign untry) ryland
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the d	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23d. Date of deli Month	23d. Date of delivery Month Day Year					
uires that uires that signed b	þ	Part II. Other significant conditions con	stributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.	I	bacco use contribute to es 2 1 No 3 ☐ Pro	the cause of death?
The law requires to the has been signed page 2 should be considered.	Completed						24a. Was a autop:	sy 📈 prior to d	topsy findings available completion of cause of
	Ö	25. Was case referred to predical				-0.01 (5		7	2 No
	00	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatier	ot oos Ot	oor:	Death Check on V		4.)
	To.	27. Manne I Death	28a. Date of Injury	28b. Time of	f 28c. Inju	ry at		ence 6 Other (Spec ow injury occurred	ary)
ding Ph th. After this funeral	tio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,	Injury	Wo	rk?]Yes 2.⊟No			
al or Attending after death. 1 Director: After d in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str cify)	reet, factory, office		28f. Location (S City or Town	treet and Number or Ru n, State)	ral Route Number,
To the Hospital or Atti within 24 hours after de To the Funeral Direct completely filled in by the	Medical	29a. Certifier 1 Certifying Phys (Check only one)	sicien: To the best of my somer: On the basis of exame and manner stated.	(nowledge, death ination and/or in	h occurred at the ti vestigation, in my o	me, date and pla opinion, death or	ace, and due to the courred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Month	n, Day, Year)
				TW	D)	8236	2 //	Tavil >	2 1007
\cap		30. Name and address of person who cor	mpleted cause of death (I	tem 23a) (Type,	Print)	U COL	1 1	1	1
7		DOVIA ESTIM	extin NI	D 70	Q Geni	e 120	al B	alt M	0 21778
	tate	31. Date filed (Month, Day, Year)	32/ Fogistrar's Sig	mature	1				
Regis	trar	MAR 2 8 200	Il Program .	K A	ask p				

DHMH 17 Rev 1/2001

ORIGINAL

07-02165 Charles Hargrov	e. II	Please Type or Print i	n Black Indelible and / Department					0050
ond range of		- For State legistrar	Certificate		u Mentai riygie	Reg. N		0968
Physicia Medical Exami	1111	1. Decedent's Name (First, Middle, Last) Charles Harar	ove TI			ite of Death onth Day Irch 20, 200	y Year 07	3. Time of Death 1745 hrs
		4a. Facility Name (if not institution, give street and n Unversity Hospital	umber)	4b. City, Town, or Baltimore	Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	y) If Under 1 Yea Months Day	11.	,	M/DD/YYYY) 9. Birt	hplace (State or number)
Director		2/9-/7-7760 1 № 2 F Jsual Residence of Decedent	19	Yrs.	De	ec. 26-	1987 Co.	untry) (SAD)
iow any		10a. State 10b. County M.D V/A	BaH,					10d. Inside City Limits 1
the Maryland 1 or 28a-f show inted at once.	Director	10e. Street and Number	4 .	10f. Zip Code	2.20	1 -	citizen of What Cour	
with the ns 23a or pe notifie	ralDi		cedent Ever in U.S. 13.	. Was Decedent of His	1239 spanic Origin? (Specify	Yes or No-	neted Si 14 Race - America	
er death , or iten	Funeral	1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes, Give Ye	2 No	If Yes, specify Cubar Yes 2 No	n, Mexican, Puerto Rican	, etc.)	White, etc. Specify: 6/4	. k
nours after the training training the training t	d be	15. Decedent's Education (Specify only highest gra	de completed) 16a. Dece		tion (Give kind of work de	one 16b	. Kind of Business/li	
136 thin 72 hou ne. than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ONE	. 20 110 / 400 / 611104,		NA	
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica	Be Cor	17. Father's Name (First, Middle, Last) Charles Hargrove,	Tr		18. Mother's Name (First,		en Surname)	
21 Duld I Mer	To B	19a Informant's Name/Relationship (Type Print)	19b. Ma	1 2 .	et and Number or Rural F	Route Number,	City or Town, State,	
e, MD 2 1 and 2 shou Health and I item 27 is r	-	Charles Havgrove, Jr	20b. Place of Dis	sposition (Name of ce	metery, Date	200	MD212 c. Location - City or	Z 9 Town, State
		1 Burial 2 Cremation 3 Removal f 4 Donation 5 Other Specify:	Mount	Ziviv Can	n. March 2	8,2007 1	Berl 40.1 "	no
Baltimo permit Pag Department Important: injury or ot		21 Signature of Funeral Service Licenses		22 Name and Address	of Facility	BALTE	F.S A	29
Physician /M di I		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.		iter the mode of dying,	such as cardiac or respi	ratory arrest, s		Approximate Interval Between Onset and Death
Examiner			unshot Wounds a consequence of):					
	Jer	Sequentially list conditions, ff any, leading to immediate cause. Enter Underlying Cause	a consequence of):					
N2. *	Examiner	Disease or injury that initiated	a consequence of):		/			
e executed tian and transit	ᇹ	d. UNPENDED AMENDED			-/			
Box 68760, e death certificate be ex the attending physician ed for use as the burial	sician/Medic	3b. Was decedent pregnant in the	outcome of pregnancy	Fetal death 3	Ectopic pregnancy	2	23d. Date of delivery	Day Year
OX 68 ceath cert	sicia	past 12 months?	nant at time of death 5	Other (Specify)		-		-,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death To the Finneral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	by Phy	Part II. Other significant conditions contributing		the underlying cause (giv in Part I. 2		co use contribute to	
ords, P						24a. Was an	24b. Were au	ably 4 Unknown topsy findings available
Recor The law r cate has b	Completed				1	autopsy performed ✓ Yes 2		ompletion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death an Director: After this certificate has been sixed in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	å	25. Was case referred to medical examiner?	Inpatient 2 ER/Outpa		of Death (Check only or Other Nursing Hom		dence 6 Other	-
ling Phy After th	n: To	27. Manner of Death 28a. Date	of Injury 28b. Time	e of Injury 28c. Inju	ry at Work? 28d.		njury occurred	
isior r Attend er death irector: n by the	Certification:	2 Accident Investigation Mar 20		s '				ral Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 V Homicide determined (Specify	Local Street		2600		nue , Baltimore , M	
o the Hc ithin 24 o the Fu	Medical	ZYAL CERTIFIER 1 Certifying Physician: To the be (Check only one) 2 ✓ Medical Examiner:On the basis and manner	of examination and/or inves					
	ž	29b. Signature and title of certifier		29c. Licens O.C.			d. Date signed (Morarch 21, 2007	nth, Day, Year)
· \		30. Name and address of person who completed car	~	up.				
ا کو ا	ate		ant Medical Examine	r 111 Penn St	reet, Baltimore, MI	D 21201		
Regist	trar	MAR 2 8 2007	Course St.	Granks)				
DHMH 17 Rev 1/2 OCME 2006	001		ORIG	INAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State Registrar Steven Wilks, M.D.

31. Date filed (Month, Day, Year)

MAR 2 8 20

32. Registrar's Signature

death with the Maryland Jennings, Irene Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Irene Mae Jennings MArch 21 2007 1:50 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Worcester Berlin Nursing and Rehabilitation Center Berlin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 31 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Mary land 1 M 2 F 80 214-24-7638 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Laurel MD Prince Geroges 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA 20707 #422 7901 Laurel Lakes Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Welty John Bolst ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3527 River Bridge Way Laurel MD 20724 Gertrude Keefer/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland National Cemetery 03/26/2007 Laurel, MD 4 ☐ Donation → ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Furieral Service Licensee Fleck Funeral Home 7601 Sandy Spring Rd Laurel MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Physician/Medical the ! for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🖾 No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other slanific þ 4 Unknown 1 🗌 Yes 2 No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date/signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per inf /866 4-4-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 232007 7:15 P. M March Catherine R. Jones 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Anne Arundel Glen Burnie Marley Neck Health & Rehab. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Feb. 11, 1938 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 ☐ M 2 🕱 F 69 219 26 2777 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Anne Arundel Linthicum 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21090 300 Regency Circle 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Social Security Admin Various 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (not available) Catherine Vernon Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linthicum, Maryland 21090 Anita Redding / Friend 300 Regency Circle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 3/28/2007 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce_Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, disyonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardial JM4/bmce Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably ™ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation

P.O. Box 68760. of Vital Records, Division

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Physician/Medical use as the ō detached Completed by page 2 rector. Be Certification: To To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to death. Medicai

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at

Pnysician

/Medical

Examiner

Baltimore, Maryland 21215-0036

State Registra

and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Annapolis, Maryland 21401

d/address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Aditya Chopia 31. Date filed (Month, Day, Year)

MAR 2 8 2007

6 Could not be determined

2 Accident

3 Suicide

29a. Certifier (Check or one) 29b. Signature

4 Homicide

600 Ridgely Avenue Suite 231

32 pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** CCIL ACKSON 12:35PM TAROLA March 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** 705 COMPASS KOAD BAltIMORE 220 1,dd (c IVER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 □ F Yrs. -34-1083 Director ILLINOIS Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. Cify, Town or Location 10d. Inside City Limits must be notified at Middle MARYLAND BAITIMORE
10e. Street and Number 1 ☐ Yes 2 No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? KOAD 21220 705 COMPASS 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: NAV Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Whi 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto OCHACTERANDSTromWHEE 12 CCHNICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 705 -WIFE CM 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any Injury or ot 1. Burial 2 Cremation 3 Removal from State PARK CEM March 30 07 orclAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ZANNINO LICENSED HOR Charles & ZANNINO LICENSED HOR 420 5 Highland Avenue Balto MD 212 21. Signature of Funeral Service Licensee 21224 ruplic lions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Part Finter the disease or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** gest ve /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or/as Completed by Physician/Medical Examiner The law requires that the death certificate be executed IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No prdemis To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred Medical Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a, Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident (Month, Day Year) Division Injury 5 Pending investigation 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3□ Suicide determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D4821

State Registrar

DHMH 17 Rev 1/2001

Hegistrar MAR 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

West

North Greene

Dr. Mark DHeuser

Baltimore

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVVERAHALLI M HARISH 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

YSICIAN

Registrar

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 42723

NORTHWEST HOSGITAL

5401 OLD COURT ROAD

29d. Date signed (Month, Day, Year)

2007

CENTER

			State of Maryland / Department of Health and I State Registrar State of Maryland / Department of Health and I Certificate of Death		giene Reg. No. 0 0	7	09695
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ith		3. Time of Death
	Physici /Medic		Melvin Kenneth Kimble, Jr.	March	21 2	Year 2007	9:05 A.™
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County	of Death	
			1805 Lansing Road Glen Burnie		Anne		
	Funeral Director		5. Social Security Number 6. Sex 1 Months 1 1 May 2 F 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. 1 Months 1 Days Hours Min.	8. Date of Birth (Month, Day Jan. 24	, Year) +, 1937	9. Birthpl Coun Mar	lace (State or Foreign try) y Land
	and w		Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location			11	0d. Inside City Limits
	Maryl -f sho	ţō	Maryland Anne Arundel Glen Burnie				1 ☐ Yes 2 X No
	r 28e	irec	10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Coun	try?
	th wit	Funeral Director	1805 Lansing Road 21060		U.S.	Α.	
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- Americ	an Indian, etc.
36	s afte	by Fi	1 Never Married 2 Amarried 1 XYes 2 No 1 Yes 2 No 1 Yes 2 No Specify:		Specify:	Whi	te
9	2 hour	edt	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bu	siness/Inc	lustry
215	hin 72 nn "na Media	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work iffe. DO NOT use retired)	king			,
21	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or items 23a or 28e-f show event, I're Madical Examiner must be notified at	Completed	11th Truck Driver		Truckin	.g	
pu	be file tal Hy d oth	Be	M-1 V-11- C	ne (First, Middle,		»)	
<u> </u>	nould J Men narke natic	၉	, Gwein	dolyn An			100
N S	d 2 st th and th si traur		19a. Informant's Name/Relationship (Type, Print) Paula Kimble / Wife 19b. Mailing Address (Street and Number or Ru 1805 Lansing Road G:	len Burn:			
စ်	Heal Heal tem 2		20a Method of Disposition 20b. Place of Disposition (Name of	Date Dulli.	20c. Location - 0		
ē	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, crematory or other place) Glen Haven Mem. Park 3/26	5/2007	Glen Bur	nie.	Maryland
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Go 4001 Ritchie Highwa				
	1		23a. art the diseas or complications that caused the death. Do not enter the mide of dying, such as cardiac	or respiratory arr			Approximate
	Physician		shock, or heart failure. List Inly one cause on each line. Immediate Cause (Final disease or condition a. A MCNeu C	AL CAN	_		Onset and Death
	/Medical		resulting in death) a. Due t ₁ (or as a con-quence of):	211100		1	41.
	Examiner		Sequentially list conditions b. 44 p. h				yeur
	Sit 9d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events c.				
H.	and and II-tran	Examiner	resulting in death) Last C. Due to (or as a consequence of):			_	
8760	cate be executed physician and the burial-transit	dicai E					
687	ificate g physas the	edic	d		=		Section 19 to the section of
	es that the death certifii igned by the attending I be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date	of delive	ry
Θ.	death	sicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Mon	th	Day Year
Q.	at the 1 by th etach	Phys	9 LI UNKNOWN				
Division of Vital Records, P.O. Box	- 0 TI	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	_		e cause of death? ably 4 Dunknown
ဓင္ပင	law requas been 2 should	Completed		24a. Was a autops	an 24b. W	ere autor	osy findings available inpletion of cause of
= =	sicien: The law s certificate has b lirector, page 2 s	Соп		perfor	med?	eath?	21 2 No
Vita	iclen: cartific ector,	Be	examiner?	th (Check only or	10)		
of	Phys this ral dir	. T	1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H 27. Mannep of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Describe b	ence 6 Othe)
o	ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?	20d. Describe in	ow injury occurre	d	
is!	Attending in death. actor: After by the fune	ifica	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office		treet and Numbe	r or Rural	Route Number,
Di	s after	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Tow	n, State)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ledicai (29a. Certifier (Check only one) 1 Octifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and or investigation and other and the basis of examination and other and the basis of examina	, and due to the c rred at the time, d	ause(s) and man late and place, a	ner as stand due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number	2	29d. Date/signed	(Month, C	Day, Year)
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_	10+		30. Narie and a ress of person who completed cause of the (Item 23a) (Type, Print) for the William of the Willi	de	Durnit	lag	2006/
	Sta Registr		31. Date filed (Month, Day, Year) 32. Aggistrar's Signature	ŧ	·		

DHMH 17 Rev 1/2001

ORIGINAL

			1 _ State	te of Marylan		irtment of F tificate of		ınd Mental H		0 0 0	7 00000
		10	Registrar 1. Decedent's Name (First, Middle, Last)	 .		imoato or	Douin	2. Date of I			3. Time of Death
	Physicia /Medic		Daniel Douglas	Craig Lott	t			Month March	2	ay Yea 3 2007	1:05pm M
	Examin		4a. Facility Name (If not institution, give street a	nd number)		4b. City, Town, o	r Location of	f Death	4	c. County of De	ath
			301 AVATOR COURT			HAVRE I					ORD CO
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	Hours	Min. (Month, i	Day, <i>Үеа</i>	9. B	irthplace (State or Foreign Country)
	Director		143-42-2762 Usual Residence of Decedent	3.	/			SEPT.	5 I	949 P.	ENNSYLVANIA
	yland now at		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	a-fsh	ctor	MARYLAND HARFORD CO		H	AVRE DE C	GRACE				1 □ Yes 2XXVo
	ith the or 28 e noi	Funeral Director	10e. Street and Number			10f. Zip Code		*	10g. 0	Citizen of What (Country?
	ath w	ral	301 AVATOR COUR			210				U.S.A.	
	item item	Ę.	11. Marital Status 12. Wa Arn 1 □ Never Married 2 【X Married 1 □	s Decedent Ever in U.: ned Forces?	S. 13. \	ryas Decedent of F f Yes, specify Cub	iispanic Orig an, Mexican,	gin? (Specify Yes or I , Puerto Rican, etc.)	NO-	Black, Wi	nerican Indian, nite, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If the 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by F	3 Widowed 4 Divorced Yes	Yes 2XXNo es, Give or Dates:		I∐Yes 2XXNo	Specify:			Specify: B	LACK
5	2 hou	Completed	15. Decedent's Education		16a. Deced	lent's Usual Occup	ation	of working	16b.	Kind of Busines	s/Industry
216	thin 7	nple	(Specify only highest grade comp Elementary/Secondary (0-12) Col	lege (1-4or 5+)	life. l	kind of work done OO NOT use retired	dunny most d)	or working	A	T YOUR	SERVICE INC.
5	ed wi ygien her th	ပ်	12th grade		SEL	F EMPLOYI					
2	be fill Had Had out	Be	17. Father's Name (First, Middle, Last)					r's Name (First, Midd	ie, Maidi	en Surname)	
2	should be ind Mental marked o	욘	CLINTON W. LOTT SR. 19a. Informant's Name/Relationship (Type. Prince)	n#)	10b Moilir	n Addroos (Street		TH LOTT r or Rural Route Num	abor Cita	v ar Taura State	Zin Codol
S	d 2 s th an th an trau			,				vre De Gr			,
9	s 1 and 1 Health tem 27 other tr		Carmen Lott/Wife 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	i	Date De GI		Location - City	
8	Pages nent of I int: If its		1 ☐ Burial ②XXCremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	trom State	-	natory or other pla EMATORY	i i	03-27-07	BA	T.TTMORE	, MARYLAND
Paltimora Manyand 01015_0008	permit. Page Department of Important: If any Injury or		21. Signature of Luneyal Service Uco	TIL.			-				ARFORD, P.A.
à	Deparition on large and large once.		Duole	uv				HIA BLVD,			
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death e on each line.	n. Do not ent	er the mode of dyir	ng, such as o	cardiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Large	ce	11 14	npho	ma			Onset and Death
4	/Medical Examiner		resulting in death)	ue to (or 😼 a 🕽 nsequ	uence of):	365	,				
- 1	Lxummer	<u></u>	Sequentially list conditions, b.	ue to (or as a consequ	nence of).						
	nsit ed	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	de to (or as a consequ	derice orj.						
07	The law requires that the death certificate be executed the has teen signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events c resulting in death) Last	ue to (or as a consequ	uence of):						
200	te be ysicial e buri	edical	d								
	rtifica ng phy as th	/ledi	IE EENALE.								
0 3	eath certifi attending for use as	an/N	23b. Was decedent pregnant	es, outcome pf pregna Live birth 2 □ Fetal		Ectopic pregnanc	,			23d. Date of o	
-	e death	Physician/M		Pregnant at time of d Unknown	eath 5	Other (specify)				WORTH	Day Year
W) 0	hat thed the defact		Part II. Other significant conditions contributing	in to death but not resi	ulting in the u	nderlying cause giv	en in Part I	23e. Di	d tobacc	o use contribute	to the cause of death?
<u>a</u> 8	w requires that the d t een signed by the should be defached	d by		.		,···g g··				4	Probably 4 □Unknown
0	t een	Completed					_	24a, W	ae an	24h Wara	autopsy findings available
2 8	The lavate has	dmo						au	topsy rformed2	prior t death	o completion of cause of ?
7 =			25. Was case referred to medical				26 Place	of Death (Check onl		No 1 □Y	es 2 No
- 5	ys is	To Be	examiner? 1 ☐ Yes 2 No Hospita	1 ☐ Inpatient 2 ☐	ER/Outpatier	it 3 DOA Oth	OF:	rsing Home 5KR		6 □Other (Si	pecify)
		n:	27. Manner of Death 1 Natural 5 Pending 28a	Date of Injury (Month, Day Year)	28b. Time o	28c. Inju				jury occurred	
7 3	Attending r death. ector: After oy the funer	atic	2 Accident investigation			M 1□	Yes 2□N	No			
++0-	or Att frer de Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e	Place of injury - At he building, etc. (Specify		eet, factory, office		28f. Location City or 1	(Street own, Sta	and Number or ate)	Rural Route Number,
/ [pital ours a eral [29a. Certifier 1 Certifying Physician:	To the best of my kno	wledge deat	n occurred at the ti	me date and	d place, and due to t	ne cause	(s) and manner	as stated
	e Hos 1 24 hr e Fun letely	Medical	(Check only 2 Medical Examiner: O	n the basis of examina d manner stated.	tion and/or in	vestigation, in my	opinion, deat	th occurred at the tim	ie, date a	and place, and o	ue to the cause(s)
	To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	PLIMS	SICIAI	29c. Licens				Date signed (Mo	
	1		· alandind	~ L1/1/2		De	5359	0		ARCH	23,2007
	11		30 Name and address of person who complete		23a) (Type,	Print) 62	,			WAY	
ı	Sta	te-	31. Date filed (Month, Day, Year)	32. Registar's Signa	iture	3	BALT	TIMORE	MD	2120	0.3
	Regist		MAR 2 8 200		· K	Coule					
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Regis

DHMH 17 Rev 1/2001

Physic /Medi Exami

Funeral Director

	State of Ma	aryland / [Оера		of H	ealth a		ental Hyg		007	0969	7
	Hegistrar 1. Decedent's Name (First, Middle, Last)		QC,	imoaic		- Cuin		2. Date of Dea	ith	. 12 12 1	3. Time of Death	_
ian	Sister Mary Eugenia L	arkin						March	Day 17	$2\overset{\mathrm{Y}e^{\mathrm{ar}}}{007}$	7:45 A. N	Л
cal ner	4a. Facility Name (If not institution, give street and number)	.		4b. City, 7	own, or	Location	of Death		4c. C	ounty of Deat	h	_
	4100 Maple Avenue			Ba1	timo	ore				Baltim	ore	
Г		e (In yrs. last bir		If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	r, Year)	9. Birt	hplace (State or Foreig untry)	jη
	578 34 0911 1□M 2⊠F	80	Yrs.					July 23	, 19	26 D.0	J.	
1	Usual Residence of Decedent 10a, State 10b, County	10c. City, Tow	n or Lo	cation							10d. Inside City Limits	s
'n	Maryland Baltimore	Ba1t									1 □ Yes 2 🛣 No	
ect	10e. Street and Number	3020		10f. Zip	Code				10a. Citize	en of What Co	untry?	_
Ö	4100 Maple Avenue			1.5	212	227				J.S.A.		
lera	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Deced			gin? (Spe	cify Yes or No- Rican, etc.)		4. Race - Ame		_
ov Fur	Armed Forces? 1	No		lf Y <i>e</i> s, sp <i>e</i> c 1 □ Yes 2		n, M <i>e</i> xicai Specify:	i, Puerto I	Hican, etc.)		Black, White Specify: Wh		
Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a	. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation Juring mos	t of workin	ng	16b. Kind	d of Business/	Industry	
Q III	Elementary/Secondary (0-12) College (1-4ors 2 vears			ired C					Reli	gious	Sister	
ပိ	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden S	Gurname)		_
To Be	William Eugene	Larkin				С	athei	rine El:	izabe	th Mer	dith	
-	19a. Informant's Name/Relationship (Type. Print)	198	. Maili	ng Address	(Street a			I Route Numbe				_
	Sister Mary Becker	41	.00	Maple	Ave	enue	Ba	altimore	e, Ma	ryland	21227	
	20a. Method of Disposition	20b. Place o cemete	f Dispo	sition (Nam	e of ther place	e) :	D	ate	20c. Loc	ation - City or	Town, State	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)						3/21	1/2007	Balt	imore,	Maryland	
	21. Signature of Funeral Service Licensee			2. Name and			GOI	nce Fund	eral	Servic	e, P.A. land 21225	
H	23a. Part1. Enter the disease or complications that cause shock, or heart failure. List only one cause on each li	the death. Do						r respiratory ar	rest.	, rial y	Approximate Interval Between	_
	Immediate Cours /Final										Onset and Death	
	disease or condition	a consequence	_	D C @n	الوح	ACL	100	FATIZO	Line,	~	Smu.	_
		a consequence	,	11-5		>20	0	X13216	58.		100	3
ē	Sequentially list conditions D. —————	a consequence	_									_
Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events											
EXa	resulting in death) Last Due to (or as	a consequence	of):									
cal	d											
Med	IF FEMALE:											_
an/	23b. Was decedent pregnant 1 ☐ Live birth	2 ☐ Fetal deatl		⊒Ectopic pro					23	3d. Date of del	livery Day Year	
Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t time of death	5[Other (sp.	ecify)							
Phy	Part II. Other significant conditions contributing to death b	out not resulting i	n the u	nderlying ca	ause aive	en in Part I		23e. Did to	bacco us	e contribute to	the cause of death?	_
Completed by Physician/Medi				وتدي	J				'es 2 🕽	0	robably 4 □Unknow	٧n
etec		- 1	(0-							`		_
mp	HIRAC FIBILLE	170N						24a. Was autop		prior to death?	utopsy findings availab completion of cause of	ie
		ا عران	5(5	2252	_			1□ Yes	2 No	1 ☐ Yes	2 1 No	_
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpati	0 T EB/O	otnoti o	-t 2□ DO	Othe			(Check only o		Пон (0		_
- T	27. Manner of Death 28a. Date of Inju	ıry 28b.	Time o	nt 3□ DO	8c. Injun	/ at		me 5 Resid			cify)	_
tion	1 Matural 5 ☐ Pending (Month, Die 2 ☐ Accident investigation	ny Year)	Injury	м	Work	<br Y <i>e</i> s 2□						
fica	3 Suicide 6 Could not be 28e. Place of in	ury - At home, fa	arm, st	reet, factory	, office		- :	28f. Location (S	Street and	Number or R	ural Route Number,	_
ert	4 Tronicide building, e	tc. (Specify)						City or Tou	m, sate)			
Medical Certification:	29a. Certifier (Check only (Ch	of examination a	e, deat	th occurred	at the tin , in my o	ne, date a pinion, de	nd place, ath occuri	and due to the ed at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)	
led	29b. Signature and title of certified	ated.				e number				signed (Moni		_
	295. Signature and the or certain					637	م		3	1210	7	
	30. Name and address of verson who completed cause of	leath /Item 22al	/Tupe		20	U) 1	<u> </u>			1 1	1	_
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ate	31. Date filed (Month, Day, Year) 32. Regist	rar's Signature										
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2001	HIGH A D COOL JUNEAU	3	OR	IGINAL								

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Parker Jenkins Leimbach	State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	tate of Maryland		tificate of De		70	eg No. 201	7 09698
Physic Medical Exam		Decedent's Name (First, Mid					2. Date of Dea Month March 22,	th	3. Time of Death 1645 hrs
incaloul Exam		Parker 4a. Facility Name (if not institut	Jenkins ion, give street and number)	Leim	bach lity, Town, or Location		4c. County of Dea	
		21 Richmar Rd. Apt				wings Mills		Baltimore Co	
Funeral Director		5. Social Security Number				Under 1 Year If Und		th (MM/DD/YYYY) 9. B Fore	
		216-34-0264 Usual Residence of Decedent	1XM 2F	68	Yrs.			17, 1939 °	ountry) MD
/ any		10a. State 10b. County	,	10c. City,	Town or Location				10d. Inside City Limits
Maryland 28a-f show 1 at once.	tor		altimore			s Mills			1 Yes 2 No
vith the Maryland s 23a or 28a-f show e notified at once.	Director	10e. Street and Number	1	-	101	Zip Code	1	0g. Citizen of What Co	untry?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-fishe or other traumatic event, the Medical Examiner must be notified at once	ral 🛭	21 Richmar R	oad Apt. (S. 13. Was De	21117 cedent of Hispanic Or	igin? (Specify Yes or No	U.S.A.	rican Indian, Black,
death or iten	Funeral	1 Never Married 2	Armed Forces' 1 Yes 2	? X No		pecify Cuban, Mexica		White, etc.	, , , , , , , , , , , , , , , , , , , ,
s after ural", o	by	3 Widowed 4 X D 15. Decedent's Education (Sp	vorced If Yes, Give Year or Dates:			2X No specify			White
2 hours af "natural" I Examin	Completed	Elementary/Secondary (0-12			during most o	sual Occupation (Give f working life. DO NO	kind of work done Fuse retired)	16b. Kind of Business	/Industry
5-0036 led within 72 Hygiene. other than 'the Medical	mple		2 Years	5	A	ccounting		Meat Pack	ing Co.
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle	,	•		18. Mothe	r's Name (First, Middle, M		
212 ould be Menta marke c even	To Be	Parker Lo	eimbach ship (Type, Print)		19b. Mailing Add	ress (Street and Nu	Rheta Jenk mber or Rural Route Num		e, Zip Code)
e, MD 21215-003 1 and 2 should be filed withi Health and Mental Hygiene, item 27 is marked other the r traumatic event, the Med		James J.J. Ob	erhaus		9742 Ea	st Hidden	Green Drive		
nore, I ages I and nt of Heal nt: If item other tra		20a. Method of Disposition 1 Burial 2 X Crematic	n 3 Removal from St		lace of Disposition rematory or other p	(Name of cemetery,	Date	20c. Location - City of	r Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other 8	Specify:			mation Ser		Hampste	ad, MD
Bal permi Depa Impo injur		21. Signature of Funeral Service	11/1/11	in		and Address of Facilite Funeral	11824	Reisterst	
Physician		23a. Part I. Enter the disease, of failure 1 ist only one caus	r complications that caused	the death	Do not enter the mo	nde of dying, such as	cardiac or respiratory arre	erstown, M	D 21136 Approximate Interval Between Onset and
/Medical Examiner		failure. List only one caus Immediate Cause (Final diseas				scular Disease	exication		Death
		or condition resulting in death)	Due to (or as a cons	equence of)):				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Dué to (or as a cons	aquanta uf).				
it it	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons-	equence of)):				
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687 ertifica ding pl	an/N	23b. Was decedent pregnant in past 12 months?	he 1 Live birth		2 Fetal de	eath 3 Ectopi	ic pregnancy	Month	Day Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Ur	4 Pregnant at 9 Unknown	time of dea	5 Other (Specify)			
ho. Box 687 that the death certification oned by the attending detached for use as t		Part II. Other significant cond	tions contributing to deat	h but not re	sulting in the under	lying cause given in P		bacco use contribute to	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safter death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	ed by	Chronic ethanolism,	pulmonary disease					2 No 3 Pro	
cord: aw req as bee	Completed						24a. Was a autop		utopsy findings available completion of cause of
Rec: The I				<u>. </u>			1 🗸 Yes		es 2 No
Division of Vital Rec spital or Attending Physician: The ours after death. neral Director: After this certificate filled in by the funeral director, page	o Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	al Hospital: 1 Inpatie	ent 2	ER/Outpatient 3	26.Place of Death		Residence 6 🗸 Othe	er. Scene
of \ng Phy		1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day, Y		28b. Time of Injury	28c. Injury at Worl		now injury occurred	
Sion Attendi death. ctor:	atio		estigation Fnd 3/22/	/2007	unk	1 Yes 2	unk		
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Ex	aminer: On the basis of exa and manner stated	mination an	nd/or investigation, i				
	Σ	29b. Signature and title of certif	er (29c. License number		29d. Date signed (Me	onth, Day, Year)
, Á		30. Name and address of perso	n who completed cause of	leath / Itom	23a)	O.C.M.E.		March 25, 2007	
1.,			sistant Medical Exan	,	•	et, Baltimore, MD	21201		
	tate	31. Date filed (Month, Day, Year	67	r's Signatur	& South	20			
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			For State Registrar	State of	Marylan		artment of				giene Rag. No.	007	09699	
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٦	Physicia /Medic		Marie Tong Liang							March			10:55 A	
	Examin		4a. Facility Name (If not institution, give		ber)			n, or Location of	of Death		4c. C	ounty of Death	m e 1877	
			Manor Care Poton				PO	tomac	24 Hrs	8. Date of Bir	*h	Montgo	lite Ly place (State or Foreign	
Ŋ.	Funeral		5. Social Security Number 6. Se	x]M 2 [X]F	Age (In yrs. 91	Yrs.	Months Da		Min	Month, Da	av. Year)	Cou	China	<i>ji</i> 1
A.	Director		Usual Residence of Decedent		91				<u> </u>	June 1	, 1)1.		OTTALL	
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limit	
	Maŋ	ţō	Maryland Montgo	nery			Beth	esda					1 ☐ Yes 2 🔀 N	10
	r 288	Directo	10e. Street and Number				10f. Zip Coo	le			10g. Citize	n of What Cou	ntry?	
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	deat	Funeral	11. Marital Status	12. Was Deced		.S. 13.1	Was Decedent f Yes, specify (of Hispanic Ori Cuban, Mexical	igin? (Spec n, Puerto F	cify Yes or No Rican, etc.)	D- 14	 Race - Ameri Black, White, 		
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. is marked other than "natural", or Iteme 23e or 28e-f show aumatic event. The Medical Exprendential be notified at		1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	2 ₩ No		1 □ Yes 2 K					Specify: As	ian	
Maryland 21215-0036	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dat	tes:	160 Dogg	dent's Usual Od	ecupation			16h King	d of Business/ir		
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au	ld be ental ked o	To Be	Paul Tong					Ros	se Wa	i				
37	shound M	-	19a. Informant's Name/Relationship (7	rpe, Print)		19b. Mailir	ng Address (St	eet and Numb	er or Rural	Route Numb	er, City or	Town, State, Zi,	p Code)	
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Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or otl once.		21. Signature of Funeral Service Licen.	:00	M01	473 Be	Name and A ethesda ethesda	dress of Facili -Chevy Mary1	Chase Land 2	rt A. Inc 20814-1	1 ump 755 3501	7 Wisc	neral Home onsin Ave	
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of Vital Record	Physician: The faw requiths certificate hes been al director, page 2 should	Completed								24a. Wa auto per 1 Yes	opsy formed?	24b. Were aut prior to c death?	opsy findings availal ompletion of cause of 22 No	ole of
/ita	cian: ertific ector.	Be	25. Was case referred to medical examiner?	Uonnital:				26. Plac	e of Death	Check only	one			-
of \	Physician: this certificant director, i	2	1 ☐ Yes Z⊠ No	Hospital: 1 ☐ Ir 28a. Date o	_	ER/Outpatie		4 00 N		ne 5 Res 28d. Describe		Other (Spec	rfy)	
n C	Jing F	lon	27. Manner of Death 1 ⊠Natural 5 □ Pending	(Monti	h, Day Year)	Injury	M 200.	Injury at Work? 1 ☐ Yes 2 ☐	1	EDG. DESCRIBE	THOW HIGHLY	00041104		
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۵	Hospital A hours Funeral ely filled	edical Ce	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the ninar: On the ba and mann	asis of examin	owledge, dea ation and/or in	th occurred at to	he time, date a my opinion, de	and place, a eath occurre	and due to the	e cause(s) a e, date and	and manner as place, and due	stated. to the cause(s)	
	To the I within 2 To the I complet	₹ E	29b. Signature and title of certifier	٤.			29c. L	cense number				signed (Month	. Day, Year)	
	->-0		Resident	-)			00	0054	566		3/2	1/07.		
•	V		30. Name and address of person who Sunita Shogan					e want	Sil	vence	7120	rin.	200106	
\$100 SA	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 8 2	32.	egiştrar's Sign	nature		CYPAU,	, , , , ,			/	72.0	
100	10 Year 10 A. F.			1		CO	The state of the s							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 1.2 per doc 8866 4-6-07 vt.
State of Maryland / Department of Health and Mental Hygiene.

			T = For State Registrar	State of Mar		ertificate of			giene Reg. No. 11 11 1	1 00700
Ш	is a second		Decedent's Name (First, Middle, La	ist)				2. Date of De	ath -	3. Time of Death
	Physici		-Mezelle McCombs	Mozell Mo	: Combs			Month March	49	907 1:30 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	noi Cii	4c. County of I	Death
18		•	HillHaven Nursing Hom	е		Adelphi			Prince Ge	orges
22	Funeral	_			In yrs. last birthday	/) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th 9.	Birthplace (State or Foreign
В	Director		577-36-5980	1□M 2XF	94 Yrs.	Months Days	Hours Min.	(Month, Da Septembe	r 14 1912 M	Country) issouri
	ō		Usual Residence of Decedent							
	how how		10a. State 10b. County	1	0c. City, Town or I	ocation				10d. Inside City Limits
	e Ma a-f s	cto	MD Prince Geo	rges A	delphi					1 K∏Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	23a ust b	la [3210 Powder Mill Rd			20783		ι	JSA	
	ems er m	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - A	American Indian, White, etc.
9	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	Æ	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 ☑ No		,	Specify: W	
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Maryland 21215-0036	2 sh and Is n raum		19a. Informant's Name/Relationship	Type. Print)	19b. Mai	ling Address (Street	and Number or Rura	al Route Numbe	er, City or Town, Sta	te, Zip Code)
	1 and Health em 27 other tr		William Teter/ Son				Way College			
9	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 [Removal from State	20b. Place of Disp cemetery, cr	ematory or other place	ce)	Date	20c. Location - City	y or Town, State
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Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any Injury or other traumatic once.		21. Signature of Function Service Lice	nsee		22. Name and Addre	ess of Facility			
	₹0 = @ ol		X Man	Will.	F	leck Funeral	Home 7601	Sandy Spr	ing Rd Laur	el MD 20707
			23a. Part1. Enter the disease, or come shock, or heart failure. List only	plications that caused th one cause on each line.	e death. Do not e	nter the mode of dyir	ng, such as cardiac o	or respiratory a	rrest,	Approximate Interval Between
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	e deg	Sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death 5	Other (specify)			World	Day Teal
л О	n requires that the d been signed by the should be detached	Phy		contributing to death but r	at reculting in the	undaduing source sh	en in Dani I	220 Did to		4- 4- 4h
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			27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time	of 28c. Injur Wor	ry at k?	28d. Describe h	now injury occurred	
DIVISION	Attending r death. ector: After by the fune	atic	2 ☐ Accident investigatio	n			Yes 2□No			
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	the h	Medical	one)	and manner state	d.					
	Vith To	2	29b. Signature and title of certifier	1118		29c. Licens			29d. Date signed (N	fonth, Day, Year)
				and asm	W~	D003156	3	M	larch 27, 20	07
	~		30. Name and address of person who	•		,				-
	15		Charles M Benner M.D			5 Silver Sp	ring MD 2090	01		
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	Registr	ar	MAD 2 8 7	107 Maria	I A	renew)				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** March 26 2007 6:25 P Lillian Noel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. September 30 1919 Baltimore Co., Md 1 ☐ M 2 ☐ xF 218 01 2207 87 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore White Marsh 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21162 11540 Philadelphia Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: þ Year or Dates: White 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 N/A Clerk Giant Food permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygir Important: If Item 27 Is marked other any injury or other traumatic event, <u>tt</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dr. John Henry Burkhardt Lilly Kunnecke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James J Brannan Sr (Son) 4915 Hazelwood Avenue Baltimore, Maryland 21206 Pages 1 ament of He 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Gardens of Faith Cem. March 31 2007 Baltimore, Maryland 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Lassahn Funeral Hone Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transi and Due to (or as a consequence of): physician Physician/Medical the for use a IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknow signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 ☐Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 20 No 6 DOther (Specify) Wosf We ဥ 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No al or Attendi s after death. 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital c within 24 hours aff To the Funeral D

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

State Registrar 4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMAN I WAVES WY 6701 N. WAVES IT TOWN MD 32 Fegistrar's Signature

and manner stated.

🔭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 8:58 a^M SHIRLEY L. NICHOLSON March 25 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GILCHRIST NURSING CENTER TOWSON BALTIMORE CO 8. Date of Birth (Month, Day, Year)
OCT. 27 19 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2XX 56 1950 MARYLAND Director 217-56-6395 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 X Yes 2 No Director MARYLAND N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 2542 MCHENRY STREET 21223 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status 7 is marked other than "natural", or iten traumatic event, the Medical Examiner Black, White, etc. 72 hours after 1 ☐ Yes 2(∑No If Yes, Give Year or Dates: 1 X Sever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽ No Specify: \$ BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS DOMESTIC 9th grade and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MERLE NICHOLSON 2 AGNES NEAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jarvis E. Smith/Son 4311 Springwood Ave., Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) LOUDON PARK CEMETERY 03-29-07 BALTIMORE, MARYLAND 21. Signature 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. ceewe 1206 W NORTH AVENUE 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as for use IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached for P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Natura 2 Accident Natural Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Name and address of person (Ener MU 222 gistrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** JULIAN ANTHONY NDUBUISI OBIOLA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**∑** M 2□ F **Director** NONE Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 28a-f sh notified Director MD Carroll Westminster 10e. Street and Number

261 Montpelier Court

Obiora Anthony Ndubuisi

1 X Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

Mar. 19, 2007 MD 10d. Inside City Limits 1 ☐ Yes 2 🛣 No 10f. Zip Code 10g. Citizen of What Country? 21157 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No Specify: Black

Hours 6

Min. 46

Olachi Mezu

2. Date of Death

8. Date of Birth (Month, Day, Year)

Month

MARCH

Day

25

Year

2007

MIA

4c. County of Death

PM

11:40

Birthplace (State or Foreign Country)

1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Sebastian Mezu - Grandfather 4011 Old Court Road, Pikesville, MD 21208

20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St. Charles Cemetery Mar. 28,2007 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service License 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 mn

Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Extreme resulting in death) Due to (or as a consequence of): Syndrome pisator Due to (or as a consequence of);

Pulmonary

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

25. Was case referred to medical examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1

Natural

5 Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

3□ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s)

24a. Was an

1∐ Yes

26. Place of Death (Check only one)

autopsy performed? Yes 2 No

28d. Describe how injury occurred

29b. Signature and title of certifier , hashin

29c. License number M.D.

P17321

29d. Date signed (Month, Day, Year) MARCH 25, 2007

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NADEEM A HASHMI, M.D. DIVISION OF NEONATOLOGY, 22 SOUTH GREENE ST. BALTIMORE, MD

31. Date filed (Month, Day, Year) State MAR 2 8 2007

2 Accident

3 ☐ Suicide

29a. Certifier

one)

4 Homicide

(Check only

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

within 2

Baltimore, Maryland 21215-0036 Physician

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Health a tem 27 is

permit. Pages 1 Department of H important: If ite any Injury or ot

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Examiner

Funeral

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Completed

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Certification: To

Medical

11. Marital Status

Division or Vital Records, P.O. Box 68760, attending physician for use as the buria page 2 s To the Hospital or Attending Physician: funeral director, After this 24 hours after death Funeral Director:

			For State		State o	of Ma	ryland	d / Depa					ental H	ygien	9			
		-	Registrar 1. Decedent's Name (First,	Middle La	ct)			Cer	tificate	e or L	Jeati	7	2. Date of D	Reg. No	20	07	3. Time of	Death
	Physicia		EUGENE										Month MARCH	Da		Year 2007	12:4:	
toji	/Medic Examin		4a. Facility Name (If not ins	titution, giv	e street and nu	mber)			4b. City,	Town, or	Location	of Death			. County			
		4	UNIVERSITY OF +	VARYLA	ND MED	ICAL	CEN	TER		BALTI					Ν	IA		
	Funeral Director		5. Social Security Number 083-18-6510	6. S	ex M∑M 2□F	7. Age	(In yrs. la 81	ast birthday) Yrs.	If Under Months	1 Year Days	Hours	er 24 Hrs. Min.	8. Date of E (Month, I July 6	Day, Year		9. Birthp Cour New Y		r Foreign
	pu: »		Usual Residence of Deceder 10a. State 10b. C				10c City	, Town or Loc	ration								0d. Inside Cit	v Limits
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	the N 28a-1 notifi	Director	MD St. 10e. Street and Number	Mary's			Great	t Mill	10f. Zip	Code				10g. C	itizen of V	Vhat Cour	ntry?	-
	3a or	JE Di	P.O. Box 34						20634					USA				
	deat	Funeral	11. Marital Status		12. Was Dec		ver in U.S	3. 13. V	Vas Deced	lent of Hi	spanic C	origin? (Spe	cify Yes or N Rican, etc.)			e - Americ	an Indian,	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2☐ 3 ☐ Widowed 4 ☐ Div		1 [X] Yes If Yes, G Year or E	2 □ No			☐ Yes		Specif					. White		
3	2 hour atural cal Ex		15. De	cedent's Ed	ducation		TIK	16a. Deced	ent's Usua	d Occupa	ation			16b. l	Kind of Bu	ısiness/In	dustry	
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<u> </u>	should od Me mark matic	2	19a. Informant's Name/Re	ationship (Type. Print)			19b. Mailin			and Num	ber or Rura	I Route Num	ber, City	or Town,	State, Ziț	Code)	unk
2	alth ar 27 Is r trau		Hannie Pap, wife	•				P.0. Bo	x 34 (Great	Mi11	MD 206	534				ŕ	
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ĺ	Page ment ant: If ury or		1 Burial 2 \(\mathbb{Z}\) Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 3/20/2007 Catonsville, MD 21. Signature of Fureral Service Licensee 22. Name and Address of Facility															
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, 2	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	by	Part II. Other significent c	onditions	contributing to d	leath but	t not resu	Iting in the ur	iderlying c	ause give	en in Par	t I.				ribute to t 3	he cause of do	eath? Jnknown
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	Exami	ner	4a. Facility Name (If not ins			,					Location of	of Death				y of Death		
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b	Funeral Director		117-24-0623		I M 2 M F	r. Age (III	73	Yrs.	Months	Days	Hours	Min.	May 2	193.	3	Count New Yor		or Foreign
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8760,	death certificate be executed e attending physician and of for use as the burial-transit	ica	that initiated events resulting in death) Last		CDue to (or as a co	nsequence	e of):										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** EULA 200 /Medical 4c. County of Death City, Town, or Location of Death ility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕱 F 08-08-1930 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Md Baltimore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 2/2/5 22. Name and Address of Facility 5240 Reiskestown Rd BalleMD Chatman-Harris F.H 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trai as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an page 2 1∐ Yes 2 NO To the Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 ပု 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Iniury 5 Pending 1 🗌 Yes 2 No investigation 2 Accident after death I Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

(Type, Print

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2007

Year)

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Dav Month Year **Physician** 16:06 PM 2007 CAROLYN PRINGLE March 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Baltimore Of Baltimore City If Under 1 Year If Under 24 Hrs. 8.
Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 57 Director MARYLAND 220-50-3748 AUG 11 1949 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Directo MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A.
14. Race - American Indian, Funeral 3627 FOREST HILL RD. 21207 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other traumatic event, the Mediconce. VSP INDUSTRIES Elementary/Secondary (0-12) College (1-4or 5+) 10th grade CUSTODIAN 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be 2 TONY ROBINSON MINNIE PENN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Pringle/Husband 3627 Forest Hill Rd., Baltimore, Maryland 21207 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 03-28-07 OWINGS MILLS, MARYLAND 21. Signature 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Maure 1206 W NORTH AVENUE 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): **Examiner** EDEMA PULMONARY Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed RENAL ACUTE burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ cate has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 MYELOGENOUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 2 12 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural Injury To the Hospital C. within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) /KUMAR RES-000 MARCH, 21 2067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

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rmit. I	any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice		LCEEIII		um, Inc. Name and Addre	ss of Facility	Europe 1	Hom	Bethes	da-Chevy			
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	completely filled in by the funeral director, page 2 should be detached for use	alc	29a. Certifier (Check only 2 Medical Exa	hysician: To the best of	f my knowle	dge, death	occurred at the til	me, date and place	, and due to the	cause(s)	and manner as	stated.			
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6			30. Name and address of person who	600 N W			Print) Balhman	244	212 62						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year LAWRENCE PERRYMAN 03 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death BALTIMORE UNIVORSITY OF MARY I AND MEDICAL CONTER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 506-90-7853 Chraska **Director** Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d Inside City Limits Prince Garges Director 1 Nes 2 No MaryLand aurai 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be r 1008 20007 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race · American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ANo Specify: <u>م</u> Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be erryman Geraldine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Streat)ister クな Yerryman Balter Laurel, MD 20007 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date HABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-31-2007 Forrest Lawn Com. Omaha, Nebraska 21. Signature of Funeral Service Licensee 22 Name and Address of Facility ALUIN F. O. BO+ 1/E. WILL any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** JEP515 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injuly) Due to (or as a consequence of): Examine burial-transit Cause (Disease or inju that initiated events resulting in death) Last Due to (or as a consequence of): physician certificate be Physician/Medical the IF FEMALE: for use If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has page 2 autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/5 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Box 68760, P.0. Records, Division or Vital the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: #

Registrar

31. Date filed (Month, Day, Year) State

(Check only one)

29b. Signature and title of certifier

MAR 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type Print)



29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene
Per H 8865 3/38/07 III
Certificate of Death
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month
MARCH 23, 2001

4c. County of Death **Physician** AGNES M. PARKER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner URE CARE CHESAPEAKE TRNOLD ANNE Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217-24-0549 1 ☐ M 2 🗷 F Months Days Hours Min Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director ANNE ARUNDEL Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1409 STEPNEY ROAD 21409 UNITEDSTATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status Armed Forces 1 Yes 2 Xivo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 <u>\$</u> 1 ☐ Yes 2 No Specify. Specify: BLACK 3XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene.

n 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) OFFICE CLERK STATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RANDALL HILLI BLANCHE BROWN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health al
Important: If item 27 Is
any injury or other trau INEPHEW STEPNEYRD ANNAPOLISIMD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CEMETERY 3 30/07 21. Signature of Juneral Service, Licenslee 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STUCA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical the I as 1 attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mor 3 Ectopic pregnancy Month Year Dav 5 ☐ Other (specify) P.O. the a detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Records, 2 pe 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform Division or Vital 2 No After this certification, funeral director, p the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural Injury 5 Pending neral Director: A investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only 29c, License number 29d. Date signed (Month, Day, Year)

State

29b. Signature and title of pertifier

21

31. Date filed (Month, Day,

Year)

MAR 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

50725

3-23-2007

x Hwy Millersville, MD 21108

Peter John Rako		1- For State	of Maryland	/ Depa	artmen		alth ar			jiene		e. 20		7 0071
Physicia Medical Exami	an/	Registrar 1. Decedent's Name (First, Middle,La Peter John Rakowsky	Jr.		Timodi				- 1	Date of De Month March 22	Day	Year		3. Time of Death 1545 hrs
		Facility Name (if not institution, given 1104 Montrose Ave				Lau	rel	r Location o				c. County of Prince Ge	eorge	
Funeral Director		5. Social Security Number 6. S 215-62-5376 1[X	ex 7. Ag	e (In yrs. I	last birthda	Yrs. If Un	oths Day		Min	8. Date of E August		1956	Foreign	nplace (State or n Pennsylvania Intry)
Maryland 28a-f show any 1 at once	ō	10a. State 10b. County MD Queen Ann	1		Town or I									10d. Inside City Limits 1 X Yes 2 No
rith the Maryland 23a or 28a-f show notified at once	Director	10e. Street and Number 106 Fox Run Lane				10f. Z 216	ip Code				10g. Cit USA	izen of Wha	t Coun	try?
death w	by Funeral		1 Yes 2 If Yes, Give Year or Dates:	X No			cify Cuba	n, Mexican, specify:	Puerto Ri	can, etc.)		White,	etc. Nhite	
136 hin 72 hours e. than "natur edical Exam	Completed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	nly highest grade com College (1-4 or 5		duri	edent's Usua ng most of w Servic	orking life					Kind of Busi ernment		dustry
21215-0036 Mental Hygiene. marked other than "natural". e event, the Medical Examiner.	8	17. Father's Name (First, Middle, Last Peter Rakowsky)					Joseph	ine Sh	elavia		Surname)		
nore, MD 2. ages 1 and 2 should ent of Health and M nt: If item 27 is m.	ပ	19a. Informant's Name/Relationship (7 Eileen Hall/ Sister 20a. Method of Disposition	Type, Print)	206	1611	S Jeral sposition (Na	d Roa	d Laur	el MD			ity or Town,		
- <u>-</u> = ± 5 = -		1 Burial 2 Cremation 3 4 Donation 5 Other Specify 24 Signature of Funeral Service Licer	:	ate	crematory	or other place Cemeter	e) ·y		03/27/			rel, MI		OWII, State
Balt Balt Bartin Departing Important		22. Name and Address of Facility 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Sprin 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stallure. List only one cause on each line.										t, shock, or heart Approximate Interva		
/Medical Examiner		failure. List only one cause on ea	Atheroscler Due to (or as a conse	otic (cardio	,								Between Onset and Death
nsi ed KA	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse											
be executed sician and unial - transit	edical	d. X UNPENDED	AMENDED #23a,PII,2	7, peri	ME, g8	66, 4/2	6/07 [IT			1144			
Box 68760, e death certificate be the attending physici ed for use as the buri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth Pregnant at	ne ot preg	nancy 2	Fetal death	h 3		pregnanc		ŀ	d. Date of do Month	Da	
. 4 >41	þ	Part II. Other significant conditions Chronic alcohol	3	but not r	esulting in	the underlying	ng cause	given in Pa	rt I		tobacco es 2	No 3	Proba	ne cause of death? abiy 4 Unknown
Division of Vital Records, P.O. Box ospital or Attending Physician: The law requires that the death hours after death uneral Director: After this certificate has been signed by the atte virilled in by the funeral director, page 2 should be detached for the funeral director, page 2.	Completed	25. Was case referred to medical					26 Plac	e of Death ((Check ppl	1 Yes	opsy ormed?	pri de		opsy findings available impletion of cause of 2 No
of Vitaling Physician After this cert uneral director	To Be			nt 2	ER/Outpa		DOA	Other ₄	Nursing H	lome 5		ence 6		Scene
Division of Vital Division of Vital Division of Vital Division of Vital Divisions after death To the Funeral Director: After this certif completely filled in by the funeral director.	Certification:	1 Natural 5 Pending Investigat	28e Place of Ini			e of Injury	1		No			and Number		al Route Number, City
Division the Hospital or vithin 24 hours after of the Funeral Direct ompletely filled in hompletely filled in homely filled in ho		3 Suicide 6 Could not determine 4 Homicide Cortifue Physics	be							or Town,	State)			
To the Hospital within 24 hours: To the Funeral completely filled	Medical	Chock chily	r:On the basis of exar and manner stated			stigation, in n	ny opinio				e and pl	ace, and due	e to the	
		Caluli	210	- 1				M.E.				rch 23, 20		, 20), . 0,
φ		30. Name and address of person who Zabiullah Ali, M.D. Assi	stant Medical Ex	aminer	111	Penn Stre	et, Bal	timore, N	/ID 2120	1				
St Regist		31. Date filed (Month, Day, Year) MAR 2 8 20[32 Registra	. 7	ire	mes								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #26 PerrPhy Coop 3/28/07 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** WILLIAM WALLACE REID March 25, 2007 10:50P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH MEDICAL CENTER Baltimore County Towson If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea Jan 24, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1∏M 2□F 87 1920 Maryland Director 213-09-9949 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show be notified at 1 ☐ Yes 2 No Director Maryland | Baltimore County 28a-f Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 220 any injury or other traumath. 2 Southerly Court, #106 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √x No Specify: WWII þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs Appraiser/Broker Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Conner Reid Bessie Regina Delano ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Southerly Court, #106, Towson, Maryland 21286 Mary Wheeler Reid (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Dulaney Valley Mem Grdns 3//29/2007 Timonium, Maryland 21. Signature of funeral Service Livensee

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemos1 **Physician** ROUV /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 No 2 400 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 DER/Outpatient 3□ DOA ပ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

29b. Signature and title of certifier

31. Date filed (Month

Timothy Souweine,

MAR 2 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

M.D., 21 West Road, Towson, Maryland 21204

29d. Date signed (Month. Day, Year)

			For State Registrar	State of Marylan		tificate of L			g. No. 🤈 <table-cell></table-cell>	7 *7	10713
	Physici	an	Decedent's Name (First, Middle, Last)			-		2. Date of Death Month	Day	Year	3. Time of Death 4:00 AMM
11	/Medic	al	Susan Jeanne Russ 4a. Facility Name (If not institution, give st			4b. City. Town. or	Location of Death	March	23, 200 4c. County o		4:00 AM
): 	Examin	er	Montgomery Genera				Derwood			gomer	су
Ē	Funeral Director		5. Social Security Number 6. Sex 1□	7. Age (In yrs. I	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/26	Year)	9. Birthpla Countr NY	ace (State or Foreign ry)
	P ,		Usual Residence of Decedent 10a. State 10b. County	10c Cib	, Town or Loc	ation				10	d. Inside City Limits
	Aaryla F shov ed at	ō	MD Montgom			ry Villa	ισe			.0	1 Yes 2 No
	the N	rect	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Countr	ry?
	th with	a D	9915 Maple Leaf D	r.		20886	i –		United	Sta	tes
900	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	1	□Yes 22 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:		Black Specify:	MILL	.te
21215-0036	within 72 h iene. than "natu the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give F life. D	O NOT use retired	durina most of work	ing	16b. Kind of Bus Public		•
and 2	ld be filed vental Hygie ked other i cevent, th	Be	17. Father's Name (First, Middle, Last) Richard Crowe	*			18. Mother's Nam			······································	
Maryland	and 2 should be lealth and Menta m 27 Is marked on her traumatic ev	ပ္	19a. Informant's Name/Relationship (Typ		1		and Number or Rui Leaf Dr.				Code) MD 20886-
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crem	ition (Name of latory or other place ake Crema	ce) ¦	Date Mar 25 2007	Beltsvi	-	wn, State Maryland
Balti	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lioshed	moo38		Name and Addres Rapp Fune 933 Gist	ss of Facility ral & Cren Ave. Silv	nation Se ver Sprin		and 2	0910-
	Physician /Medical Examiner	0.00	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death e cause on each line. Palmond Due to (or as a consequence)	14 1	er the mode of dyin		or respiratory arre	est,		Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)							
P.O. Box 6	death cartif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ic. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ì death 3□	Ectopic pregnancy Other (specify)	/		23d. Date Mon	e of deliver	ry Day Year
	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause giv	en in Part I.	23e. Did tob			e cause of death? ably 4
or Vital Records,	The ate h page	Completed						24a. Was al autops perform 1 Yes 2	y pi	rior to com eath?	osy findings available apletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		3 DOA Oth	OF.	th (Check only on			
o	Phys this ral dir	. To	1 Yes 2 100 17	28a. Date of Injury	ER/Outpatient 28b. Time of	J DOA	4 🗆 Nursing 🖂	ome 5 Reside)
on	Attending Phr r death. ector: After th by the funeral	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 □	k? Yes 2∐No		,,		
Division	al or Atter s after dea! I Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif		eet, factory, office		28f. Location (St City or Town		er or Rural	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		ician: To the best of my kno er: On the basis of examina and manner stated.							
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier			29c. Licens	se number 2989		9d. Date signed		
	Ji		30. Name and address of person who col				(+		w / · ·	u e c	
	Sta	ate	Den is O'llrien 31. Date filed (Month, Day, Year) MAD 2 8 2007	32. Registrar's Sana	ture	e wood					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Roger Rosenthal March 2007 11:30P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Olney If Under 1 Year Montgomery General Hospital Montgomery

9. Birthplace (State or Foreign Country) If Under 24 Hrs. Social Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X**] M 2□ F Yrs 059-26-5234 9. Director Feb. 1934 New York Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.

item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The marked other than "natural" or items 23a or. In any injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event. 4520 Prestwood Drive 20832 United States Funeral Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1XX es 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: δ 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical 5+ Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valerie Stern ဂ Jesse Rosenthal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Rosenthal/Son 4520 Prestwood Drive, Olney, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State March 27, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Bethesda, Maryland Pumphrey Funeral Home Crematorium, Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Weensee Rockville, Inc. 300 West M Rockville, Maryland 20850-2

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MISTASMIC LING ADENGENCINONA W month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the bunal-tran and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 INO 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760, Division or Vital Records, after death. within 24 hours a To the Funeral [

41

State

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JANGON,

MAR 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ww

DHMH 17 Rev 1/2001

3416 OLANDWOOD

32. Redistrar's Signature

I 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

iour,

SUITE

200

29d. Date signed (Month, Day, Year)

OLMEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.C.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 22, Day 2007 Year Physician 12:15 PM Sathyabhama Devi Roy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🔯 F Yrs. 565-70-2209 May 20, 1931 India Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any lury or or other traumatte event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 United States 319 Summit Hall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian-Indian Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Science Computer Programmer 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Sita Bai Vedavyasa Acharya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Summit Hall Road, Gaithersburg, Maryland 20877 Joydeb K. Roy/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 31, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) Crematorium, Inc. 200/ 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase Inc. 2007 21. Signature of Funeral Service Licensee M00198 7557 Wisconsin Ave., Bethesda, MD 20814-3501

23a. Partt. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** avdiczenie /Medical Due to (or as a consequence of): **Examiner** d 051 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner rige ig physician and as the burial-tran Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 1) TQJE 11 700 26. Place of Death (Check only one, Be Other: 4 Nursing Home Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 □ Yes 2 □ No Fo the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29b. Signature and title of certifier dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 79 29

Registrar

31. Date filed (Month, Day,

ORIGINAL

32. Registrar's Signature

			1 - For State Registrer		State of M	aryla			nt of H	ealth a	and M	lental H		e 200	7	09	716
	Physic	ian	Decedent's Name (First,	Middle, Las	t)							2. Date of D		ay Y	ear	3. Time	of Death
	/Medi		Pierina				·					MAR			007	02	-55 HM
	Exami	ner	4a. Facility Name (If not ins		4					Location o			4	c. County of			
	Funeral	_	5. Social Security Number	16. Se	reneral H		. last birthday		Olux	nb-a		8. Date of B	irth	Howa	200	dana (Cta	10 and Commission
н	Funeral Director		220-50-9035				77 Yrs.	Months		Hours	Min.	(Month, I	Day, Yea.	7)	Cour	itry)	te or Foreign
	P .		Usual Residence of Deced														
	show	7	10a. State 10b. C	ounty		10c. C	ity, Town or L	ocation							1		City Limits
	the M	ecto		Arund	e1	Laui	rel						1				es 2 No
	72 hours after death with the Maryland natural", or Iteme 23a or 28a-f show after Examiliar must be motified at	Funeral Director	10e. Street and Number	- C13	_			10f. Zip						itizen of Wha	at Cour	ntry?	
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93	rai", c	1 by	3 ☐ Widowed 4 ☐ Div	orced	If Yes, Give Year or Dates:			1 🗆 Yes	2 🔼 No	Specify:				Specify: \	White	е	
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Maryland	shound M	-	19a. Informant's Name/Rel	-	ype, Print)		19b. Maili	ng Address				I Route Num	ber, Citv	or Town. Sta	te. Zio	Code)	
	alth a		Jerry Sapienza,	Husbar	nd							MD 207		, ,		0 0 0 0	
Baltimore,	of Healt fitem 2 r other		20a. Method of Disposition 1 Durial 2 Cremi	o 🗆		20b.	Place of Dispo	sition (Nar	ne of			ate	_	ocation - Cit	y or To	wn, State	
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	Physician /Medical		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	se, or comp List only o	lications that caused ne cause on each li a	Hir	Shock	er the mod	e of dying	, such as c	cardiac o	r respiratory	arrest,			Approxim Intervat E Onset an	d Death
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P.O. B	The law requires that the death certificate be executed ste has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 Yes 2 XNo 9 Unknown		1□Live birth 4□Pregnant at 9□Unknown			Ectopic pro Other (sp						23d. Date of Month		Day	Year
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Ë	Jing I	ion		ending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		Bc. Injury			8d. Describe	how intu	ry occurred			
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<u>></u>	2 # # E	Certification:	4 Tromede	termined	building, etc	. (Specif	(y) 					8f. Location (City or To	wn, State	э)			moer,
	To the Hospital within 24 hours e To the Funerel C completely filled	Medical	29a. Certifier 12 Cer (Check only 2 Med	ical Exemi	sicien: To the best of ner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	, date and nion, death	place, ai occurre	nd due to the d at the time,	cause(s date an) and manne d place, and	r as sta due to	ited. the cause	·(s)
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			* Alun	ide	an 1	up			D4:	000	>		130-	we b	> >	> -	000
	ic		30. Name and address of pe	rson who co	mpleted cause of de	eath (Iten	n 23a) (Type, I	Print)	~ [-01			1110	TURE	<u> </u>	100	U
	15			iuid	-		107	24 6	ittle	Pat	uxe	wt PK	WV.	Colum	bia	mo	21044
	Sta Registr		31. Date filed (Month, Day, MAR 2 8	^(ear) 2007	32. Registra	r's Signa	ture	· St					/			,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Anadgavari A Suthar AM /Medical March 2007 9:06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3910 Braveheart Circle Frederick Frederick If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Min Hours 1 □ M 2 V F Yrs Director 215-08-7852 81 July 22 1925 India Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 KTYes 2 □ No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3910 Braveheart Circle Funeral 21704 India 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black. White, etc 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Asian þ 3 Nidowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 traumatic Chunilal Suthar Kamla Suthar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health al
Important: If Item 27 is
any injury or other trau Mahesh Suthar, son 8804 Gingerbread Court Gaithersburg MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 3/24/2007 Catonsville, MD 21. Signal re of Fuer Service Licenses 22. Name and Address of Facility Fleck Funeral Home 7601 sandy Spring Rd Laurel MD 20707 Nom 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Ischemia /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus II Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last vears Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 🖾 No Month Year 4□Pregnant at time of death 5 Other (specify) the a∏lJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronory Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 2 💢 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 💢 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: After this Director: 24 hours a the

0 4

cal

State Registrar

DHMH 17 Rev 1/2001

Gauraug Thacker MD 3411 Olanwood Court, Onley MD 20832 31. Date filed (Month, Day, Year) 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

5 Pending

investigation

6 Could not be determined

29b. Signature and title of certifier

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D43430

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

March 22 2007

29d. Date signed (Month, Day, Year)

		Please T 1 - Stete Registrer	ype or Print in State of Maryla	ınd / Depa		Health and M	lental Hy		egible.	09718
Physici		Decedent's Name (First, Middle, Last) ILLI			TT. Jr		2. Date of De Month		Year 2007	3. Time of Death 7: 35 PM
/Medic Examir		4a. Facility Name (If not institution, give s		3 - 0	4b. City, Town, o	or Location of Death			unty of Death	1
Funeral Director	*	223-26-0710		rs. last birthday) Yrs.	Baltim If Under 1 Year Months Days		8. Date of Bird (Month, Da July 4,		Cou	place (State or Foreign ntry) ginia
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD		City, Town or Lo	cation					10d. Inside City Limits 1X Yes 2 ☐ No
with the 3e or 28	I Dire	10e. Street and Number 3607 W. Garrison	Avenue		10f. Zip Code 21215			10g. Citizen	of What Cou	ntry?
should be filed within 72 hours after death with the Maryland and Mental Hygiene. Marked other than "neturel", or litems 23e or 28a-f show imatic event, the Medical Evantiner must be notified at	by Funeral Director		2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	'	Was Decedent of h	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,	, etc.
"neture	Completed	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted</i>)	16a. Deceo	dent's Usual Occup	pation during most of work d)	king	16b. Kind	of Business/Ir	ndustry
od within 72 hours af giene. er than "neturel", or	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Mecha					omotive	9
of 2 should be filed 2 should be filed the and Mental Hy 7 is marked other traumatic event.	To Be (17. Father's Name (First, Middle, Last) William Henry Sco	tt, Sr.			18. Mother's Nam	e (First, Middle, Thomps		mame)	
nd 2 shou lith and M 27 Is mar	_	19a. Informant's Name/Relationship (Type Roselia B. Scott	oe, Print) (Daught			I .	ral Route Numbe	er, City or To		
Dartillion of war your permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked enty injury or other traumatic a once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	natory or other pla	Cem. 3-29	Date		ion - City or T	own, State
permit. F Departme Importar eny injur		21. Signature of Funeral Service License			Name and Addre	oss of Facility Ott Funer	al Home	Loon	2000	
Physician /Medical Examiner		23a. Prt1. Enter the disease, or complic shock, heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the de cause on each line. Due to (or as a cons	F C					VA _	Approximate Interval Between Onset and Death
be executed sician and burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons							
ath certificate	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □Live birth 2 □Fc 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnanc	у		23d	. Date of deliv	ery Day Year
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	Completed						24a. Was autor perfo 1 \(\text{Yes} \)		4b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of 2 No
ysician: is certific director,	To Be	25. Was case referred to medical examiner?	ospital: 1 XInpatient 2	□ EB/Outpatien	t 3 DOA Ott	26. Place of Dea	th /Check only come 5 Resid		Other (Speci	fv)
ng Ph ter th		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Inju Wo		28d. Describe I			97
of or Attendi s after death. I Director: A	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, str cify)	eet, factory, office		28f. Location (S City or Tov	Street and N vn, State)	umber or Run	al Route Number,
To the Hospitel or Attendition 24 the Market of Attendition 24 hours after death. To the Funerel Director: A completely filled in by the tu	Medical C	29a. Certifier Certifying Phys (Check only one)	icien: To the best of my ker: On the basis of examinand manner stated.	nowledge, death	occurred at the ti	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and date and pla	d manner as s ace, and due t	stated. the cause(s)
To th withir To th comp	Me	29b. Signature and little of certifier	MD		29c, Licens	064533		3 23	igned (Month,	7
5		30 Name and address of person who con BABATUME M.	mpleted cause of death (III	tem 23a) (Type,	Print) LEVIN	DAZE HE	RREN	GERIA NE.B	ALTIMO	CE, MD2121
Sta Regist		31. Date filed (Month, Day, Year) MAR 2 8 200	32 Registrar's Sig	nature	de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 6:55 AM Stewar Nesley 0 3 2007 Davio /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bal NIA HOSPITAL quare timor If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 216-58-315 1**X** M 2□ F Yrs. Director 03 53 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director Roseda MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. A. 21237 ulast 12. Was Decedent Ever in U.S. Armed Forces? Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ☑ Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MeDI nΑ echnician permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stewar Marian Harvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stewart-Daughter 1906 North Saratoga Street, Baltimore, MD 21223 AlFreda 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 Burial 2 □ Cremation 3 Removal from State 24-07 Randallstown 4300 Wabash Ave Injury o 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fuperal Service Licensee F/H West Baltimore, mD march 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arrest **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Failure - End stage Kenal if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine with heart Failure certificate be executed cardio myo pathy
Due to (or as a consequence of): and Box 68760. attending physician Physician/Medical CVA as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 0 in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9∏Unknown 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Pressur 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy performed? 1□ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division or Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ို 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philadel Baltomore, Maryland Phia Rd M.D 108 Kim 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23. 254 **Physician** 25 500) Swann Jr. /Medical James 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** AGNES HOSPITAL TIMORE
If Under 24 Hrs. 8 If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours 1**X** XM 2 □ F 73 bі 08 NC Director 229-34-6164 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 Yes 2 No Director Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or U.S.A. 21229 Funeral 3710 Woodridge Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? an "natural", or items Medical Examiner mu 1 Yes PNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Supervisor General Motors 8th grade permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sultena Hairston 2 James Swann Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3710 Woodridge Road, Baltimore, Md 21229 Phyllis Swann-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 3/30/07 Randallstown, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee March F/H West 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 4300Wabash Ave, Baltimore, md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final ardiac **Physician** Arrythmia 5 minutes disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Joryana Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown hypertension Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6699 14795 2007 Much 25, MD

3

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State
State
Registrar

State

30. Name and address of person

900 South Caton
32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Signature Agaili

ORIGINIAL

Ballimore, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat 12017 21, 2007 **Physician** Elmer W. Steinkraus /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1/200 Washington If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Funeral Months Days 1 ▲M 2 ☐ F 90 212 01 5723 Director 20, 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show iral", or Items 23a or 28a-f show Examiner must be notified at Maryland Anne Arundel Arnold 1 ☐ Yes 2 TX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 Severn Wav 21012 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after thygiene. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed by 3 ☐Widowed 4 ☐ Divorced If item 27 is marked other than "natural", or other traumatic event, the Medical Exa 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Accountant W.R. Grace Chemical Co. vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f permit. Pages 1 and 2 should be Department of Health and Mente Important; If item 27 is marked any Injury or other traumatic ev Gustav Steinkraus Julia Thomas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Steinkraus / Brother 122 Severn Way Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Asbury United Meth. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/23/2007 Arnold, Maryland 4 Donation 5 Dother (Specify) Church Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. List Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine for use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 2 ER/Outpatient 3 DOA funeral 27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)
MAR 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

BOM

		1	For State Registrar	State of Mary		artment of Heartificate of De			iene	07	0972	2
			1. Decedent's Name (First, Middle, Last,					2. Date of Dea Month	th Day	Year	3. Time of Death	
	Physicia /Medic		Audr	ey Shappe	e11			March		2007	4:10 P.	М
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Death			ty of Death		
			Morningside House			Hanover	Under 24 Hrs.	o Date of Blat		e Arur		
	Funeral Director		214 24 0041	7. Age (In	yrs. last birthday) Yrs.		House Min	8. Date of Birth (Month, Day Sept. 1	Vear)		place (State or Forei ntry) aryland	gn
	and *	}	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside City Limi	ts
	Maryl.	ō	Maryland Anne A	rundel	Hanover						1 ☐ Yes 2 🔀 N	10
	sa or 28a-	Funeral Director	10e. Street and Number 7548 Old Telegr	aph Road		10f. Zip Code 2107	76	1	0g. Citízen o	f What Cour	itry?	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28a-f ehow or other treumetic event, the Modical Exami	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☒ No	anic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	ВІ	ace - Americ lack, White, cify: Whi	etc.	
200	72 hou	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occupation	on ing most of worki	ng	16b. Kind of	Business/Inc	dustry	
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21	filed w Hygier other th		12th			Accountant	B. Mother's Name	(First Middle			Tity Admi	
and	be fill	Be	17. Father's Name (First, Middle, Last) Leste	r Andrew Ja	ckson	1		Rigler	Walden Sunn	1110)		
ž	should nd Mer marke umetic	^L	19a, Informant's Name/Relationship (T)			ng Address (Street and			r. City or Tow	m, State, Zip	Code)	
Ma	id 2 s Ith an 27 Is I treui		William E. Shap			Livingston					, F1. 337	702
altimore,	ages 1 and ont of Health t: If item 27 y or other to	18	20a. Method of Disposition 1 3 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	removal from State		osition (Name of matory or other place)		/2007]	20c. Location	-	own, State	
Baltir	permit. Pages i Department of F Importent: If ite any injury or ot ance.		21. Signature of Funeral Service Licens		1 2	2. Name and Address					e, P.A. and 21225	5
			23a. Part1. Enter the disease, or composhock, or heart failure. List 1000 of	lications that caused the	death. Do not en	ter the mode of dying,	such as cardiac o	or respiratory are	est,		Approximate Interval Between	
			Immediate Cause (Final		_						Onset and Death	,
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	uted J ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Union Hig Cause (Disease or injury that initiated events									
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.O. Box	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive	ery Day Year	
<u>α</u> .	ires that the de signed by the a d be detached f	by	Part II. Other significant conditions co	entributing to death but n	ot resulting in the u	inderlying cause given	in Part I.	23e. Did to			he cause of death?	wn
Records,	law requir as been si 2 should l	Completed						24a. Was		b. Were auto	opsy findings availal	ble
Re	The la	Com						perfo		death? 1 ☐ Yes	2 No	
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only o	ne)		A COURT	
of V	Physicien: this certific ral director,	P	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatie		4 Nursing no		-/-	Other (Specia	פייועוע (מ	_
	ding P J. After t funera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Work?	at es 2 □ No	28d. Describe h	low injury occ	urrea		
Division	deatl ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm, st Specify)			28f. Location (S City or Тои		mber or Run	al Route Number,	
	To the Hospital or At within 24 hours after o To the Funerel Direct completely filled in by	edical Ce	(Check only 2 Medical Exam	ysician: To the best of miner: On the basis of ex	amination and/or in	th occurred at the time nvestigation, in my opin	, date and place, nion, death occurr	and due to the red at the time,	cause(s) and date and plac	manner as s e, and due t	stated. to the cause(s)	
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner stated		29c. License			29d. Date sig	ned (Month,	Day, Year)	
	Can	1	1110		l. (h 22)	D37	111		-1-			
	(D)		30. Name and address of person who	0	h (Item 23a) (Type		21225					
	St	ate	31. Date filed (Month, Day, Year)	32. Strar's		8-10-	2-10-22					
	Regist	rar	MAR 2 8 2	007 Deserve	· B. B.	person						
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Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	-				nd Mei	ntal Hyg	jiene			
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nd.	Examin	er	6912 Anchorage Dr				Bethe		Deali			Montgome	277	
	Funeral	11.70	5. Social Security Number 6. Second		e (In yrs. last birth		If Under 1 Year	If Under 24	Hrs. 8.	Date of Birth		9. Birth	place (State of	r Foreign
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	p ,		Usual Residence of Decedent		10c. City, Town	or Long	ion						10d Inside Cit	- I iik-
	shov	'n	Maryland Montgome	277	Toc. Oity, Town	OI LOCAL		hesda					10d. Inside Cit 1 ☐ Yes	
	the N 28a-f	Director	10e. Street and Number	- L y			10f. Zip Code	nesua		1	Ina Citi:	zen of What Cou		
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at		6912 Anchorage Dr	ive			2081	7				United S	1	
	ms 2%	Funeral		12. Was Decedent I	Ever in U.S.	13. Wa	s Decedent of Hi	spanic Origin	n? (Specify	y Yes or No-		14. Race - Ameri		
9	after or ite	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ N	w World		es, specify Cuba		Puerto Ric	can, etc.)		Black, White,	etc.	
03	ours :	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	War II		Yes 2⊠ No	Specify:				Specify: W]	nite	
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d 2	be filed within 72 hours after death with the Marylan ntal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)			2115.		18. Mother's	s Name (F	First, Middle,			I.L	
an	d be ental ked o c eve	To Be	James Logan Seale				į	Nanni				,		
Maryland 21215-0036	2 should be and Mental is merked or aumatic ev	_	19a. Informant's Name/Relationship (Ty	oe. Print)	19b. I	Mailing A	Address (Street a		-		r, City o	r Town, State, Zij	Code)	
	and 2 salth salth s		Gary Seale / Son		78	49 (Godolphi	n Driv	ve, S	pringf	ielo	d, Virgi	nia 22	153
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is merked any injury or other traumatic erone.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of E cemetery	, cremat	tory or other plac	e) M;	Date arch	26.	20c. Lo	cation - City or T	own, State	
Ĕ	Pages ment of lant: If ite		4 □ Donation 5 □ Other (Specify)	emovar nom ciate	Monta	geme Heor	Tum Inc		2007			hesda, M		
Salt	permit Depart Import any in		21. Signature of Funeral Service Licens		M01433	Bet	lame and Addres hesda-Cl	s of Facility	kober hase.	rt A. I	ump 755	hrey Fui 7 Wiscon	neral H nsin Av	lome/
	₽□ = 6 0		On Park Fatar the disease or small			Bet	hesda, N	laryla:	nd 20	0814				
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final					y, such as ca	aruiac or re	espiratory arr	est,		Approximate Interval Betwood Onset and D	veen Death
	Physician /Medical		disease or condition resulting in death)		dial Inf		tion							
	Examiner	Coronary Artery Disease												
	# 56	ner	Sequentially list conditions, that y, cooling to him school cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of									
1	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events											
8760,	oe execian a	Ě	resulting in death) Last	Due to (or as	a consequence of):								
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0 × 6	the death certific y the attending p ched for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	pf pregnancy						1,	23d. Date of deliv	en/	
Box	death a atter	iciar	in the past 12 months?	1□Live birth 4□Pregnant at	2 ☐ Fetal death time of death		ctopic pregnancy ther <i>(specify)</i>	_				Month		'ear
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ecc	has be	Completed								24a. Was a autops	sv	24b. Were auto	opsy findings a	available ause of
<u>~</u>		Con								perfor	med? 2 🔯 No	death? 1 ☐ Yes	2□No	
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or	g: is: 5	5	1 ☑ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	lospital: 1 ☐ Inpatie 28a. Date of Inju			3 DOA Othe	4 🗆 110151		5 🔀 Reside		Other (Speci	fy)	
Division or Vital Records,	ding h. After funer	tion	1 ☑ Natural 5 ☐ Pending	(Month, Day	Year) 200. Inj	ury	28c. Injun Work	(? Yes 2 □ No		a. Describe in	ow injury	y occurred		
/ISI	Attending Ir death. ector: After by the funer	fica	3 Suicide 6 Could not be	28e. Place of inju	ıry - At home, farn	n, street				. Location (Si	treet and	d Number or Run	al Route Numi	ber,
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	the Hospital hin 24 hours a the Funeral I πpletely filled		29a. Certifier 1 ☐ CertifyIng Physical Exami)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one)	and manner sta			29c. License							
	or with	_	29b. Signature and title of certifier	8006	MIN			57846		2		e signed (Month, ch 22,		
	"KX"	}	30. Name and address of person who co	molecularity	eath (Itom 22a) (T	vne Det	nt)							
	(2)		David W. Hirshfie					, #100), Be	thesda	, Ma	aryland	20817	
	Sta		31. Date filed (Month, Day, Year) MAR 2 8 20	32. Fegistra	ar's Signature	Ma	all's							
	Registr	ar.	M ハリンド /	CELT I AT SOLUTION	WE I AI	ARTICL CO.	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O3 23 **Physician** 2007 7:30p M Taylor E. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 419 Thornfield Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 Month, Day. | 10. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 46 **Funeral** Months 1 ★M 2 ☐ F 60 Director 212-44-7085 Usual Residence of Decedent 10h County 10c. City. Town or Location 10d, Inside City Limits show rral", or items 23a or 28a-f shov Examiner must be notified at 1√2Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21229 by Funeral 419 Thornfield Road death 12. Was Decedent Ever in U.S. Armed Forces? 1√J Yes 2 ☐ No IFYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 € Divorced 'natural", I am and Mental Hygiene.
Item 27 Is marked other than "natural than the Medical I Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Scientist University of MD 12th grade or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robbie A. Taylor 2 Burnel Stokes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1559 Winston Ave, Baltimore, Md 21239 Betty Rice-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ott Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 4/2/07 owings Mills, Md 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Pheumoinia weeth /Medical Due to (or as a consequence of): **Examiner** curon Craphagan 16 months Sequentially list conditions, if any, leading to immediate cause. Litter or anymy Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an s certificate has b autopsy performed 1□ Yes 2☑No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To after death.

I Director: After this d in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

Aucha Doyle mo Greenelsaum 31. Date filed (Month, Day, Year). 32. Registrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walle

Chectari

29b. Signature and title of certifier

Been &

29c. License number

D 23809

Cancer Ur., 22 S. (neare St.,

29d. Date signed (Month, Day, Year)

Balt, mp

27, 2007

21201

March

State of Maryland	Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 7 0 9 7 2 5
Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
Physician Delbert Virgil	Tullius, Sr. March 24 2007 6:00 A. M
/Medical	4b. City, Town, or Location of Death 4c. County of Death
308 - 6th Avenue	Baltimore Anne Arundel
Funeral S. Social Security Number 6. Sex 7. Age (In yrs. last	Months Days Hours Min. (Month, Day, Year) Country)
Director 298 18 1728 Usual Residence of Decedent	Yrs. Sept. 9, 1924 Ohio
D	own or Location 10d. Inside City Limits
Maryland Anne Arundel Ba	timore 1 □Yes 2∯No
10a. State 10b. County 10c. City, T Maryland Anne Arundel Ba. 10a. State 10b. County 10c. City, T Maryland Anne Arundel Ba. 10a. State 10b. County 10c. City, T Maryland Anne Arundel Ba. 10b. County 10c. City, T Maryland Anne Arundel Ba.	10f. Zip Code 10g. Citizen of What Country?
308 - 6th Avenue	21225 U.S.A.
308 - oth Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 1 Styles 2 No lifyes, Give 3 3 Stwidowed 4 Divorced 1 Styles: WW II	1 ☐ Yes 2 to No Specify: Specify: White
10a. State 10b. County 10c. City, T 10c. Cit	Sa. Decedent's Usual Occupation 16b. Kind of Business/Industry
	(Give kind of work done during most of working life. DO NOT use retired)
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Sth 17. Father's Name (First, Middle, Last)	Master Mechanic Factory
で 三工芸	18. Mother's Name (First, Middle, Maiden Sumame) Dora Mae Gates
Andrew Tullius 19a. Informant's Name/Relationship (Type, Print) Constance Stacey / Daughter	9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Constance Stacey / Daughter	514 Alden Street Baltimore, Maryland 21225
20a. Method of Disposition 20b. Place	of Disposition (Name of Date 20c. Location - City or Town, State tery, crematory or other place)
1 🗷 Burial 2 □ Cremation 3 □ Removal from State Glen	Haven Mem. Park 3/28/2007 Glen Burnie, Maryland
20a. Method of Disposition 1	22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225
23a. Part 1. Enter the disease, or complication, that caused the death. I shock, or heart failure. List only one cause on each line.	IIIfel A II Defination
Immediate Cause (Final disease or condition Pancereation	Cancer 2 mos
/Medical resulting in death) Due to (or as a consequent Examiner	se of):
Sequentially list conditions b.	30 cd):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	As off.
that initiation events c.	se of):
the purisic of the pu	
9 = 7 9	
Work of the past 12 months? IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
	5 Other (specify)
	g in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
S D S S S D S S S S S S S S S S S S S S	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
The law require alle has been si page 2 should l	24a. Was an 24b. Were autopsy findings available
The lav rate has page 2:	autopsy prior to completion of cause of performed? death? 1 □ Yes 2 □ No
The second of th	26. Place of Death (Check only one)
25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER 28 Date of Injury 28	Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
28a. Date of Injury 28 (Month, Day Year)	b. Time of liqury at Work? 28d. Describe how injury occurred
Value of the control	M 1 Yes 2 No farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
building, etc. (Specify)	City or Town, State)
The state of the best of my knowle of the best of my knowle of the best of my knowle of the best of th	dge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
one) and manner stated.	and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
Korecte Dout Li Mis.	D396660 march 27, 2007
30. Name and address of person who completed cause of death (Item 23) Robert C. Dout, Jr. MD. 901	a) (Type, Print)
THE TYPICAL CARACTER AND WILL WILL SHOW	E Con Lio Bultimore MIN 217-213
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar NAR 2 8 2007	E. For two. Builtimere, mus 21230

		. For	State of			artment of H			_		gibic.	
	1	- State Registrar			Cei	tificate of L	Death			Reg. No. 2	007	09726
Physicia		1. Decedent's Name (First, M.	Charles	Tayl	0 1			1	2. Date of De 1 Month	ath Day	2007	3. Time of Death
/Medic Examin	al -					4b. City, Town, or	Location o	- 18			unty of Death)
Examin	er	Baltimore Reb	abilitation	Extende	d Care	1	Balti:			Bal	timore	City
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under	24 Hrs. 8	B. Date of Bir (Month, Da	th v. Year)	9. Birth	nplace (State or Foreign intry)
Director		212-42-2985	1 ⊠ M 2□F	63	Yrs.	WOTHING Days	Tiodis		01/01	1944	PA	
pur *	-	Usual Residence of Decedent 10a. State 10b. Cou		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
Aaryla I eho			ford		re De							1 Yes 2 □ No
the h	Director	10e. Street and Number				10f. Zip Code				10g. Citizer	of What Cou	intry?
death with the Maryland ms 23a or 28a-f ehow rount be notified at	<u>~</u>	200 N. Washin	gton Ave. #	101		21078				USA		
deat	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Ori	gin? (Spec	ify Yes or No	14.	Race - Amer Black, White	
0036 hours after ural; or Ite		1 Never Married 2	Married 1/20 Yes	2 □ No e		1 □ Yes 2 No	Specify:			ł	ecify: Whi	
hours fural:	ed by	3 ☐ Widowed 4 ☑ Divor	ced Year or Da	ites:	16a Dece	dent's Usual Occupa	ation				of Business/I	
vithin 72 ene. then "net	Completed	(Specify only hi	ghest grade completed)	404 5 . \	(Give	kind of work done of DO NOT use retired	during mos	t of workin	9	Medic		,
d with	E	Elementary/Secondary (0-1	2) College (1	-401 5+)	Sales							
laryland 21215-0036 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene Ie marked other than "natural", or Items 23a or 28a-1 ehow aumatic event, the Marylan Examinator was be notified as	Bec	17. Father's Name (First, Mid						er's Name Grub	(First, Middle	, Maiden Su	mame)	
aryland should be and Mental marked o	2	George Arthur					Mae					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or any Injury or other traumatic event, the Medical Explosion.		19a. Informant's Name/Relate Holly Taylor/I				ng Address <i>(Street a</i>					own, State, Z	ip Code)
Healt	-	20a. Method of Disposition		20b. P		sition (Name of natory or other place		Da	ite		tion - City or	Town, State
nor		1 ☐ Buriat 2 Cremati 4 ☐ Donation 5 ☐ Othe	ion 3 Removal from 3			na <i>tory or other piac</i> ke Cremat			ar 26 007	Belts	ville,	Maryland
Baltimore, Dermit. Pages 1 ar Department of Hea Important: If Hem any Injury or othe		21. Signature of Funeral Sen				Name and Address remation				atiros		
Departimbo		Fredal	ne Rulla	MOLYY	-	717 Green						ryland 21286
. *		23a. Part1. Edter the disease shock, or heart failure.	e, or complications that callist only one cause on e	aused the deatl ach line.	h. Do not ent	er the mode of dyin	ig, such as	cardiac or	respiratory a	irrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Finat disease or condition	_a Me	tasta	tic (colon (anc	ev				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	Cercis						
	-	Sequentially list conditions,	b. Due to	or as a conseq	uence of):	<u> </u>						
betr Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	,	,							
760, e be executed sician and e burial-transit	Еха	resulting in death) Last	C. Due to (or as a conseq	uence of):							
	Cal		d									
c 68 artifical ing phy e as th	Med	IF FEMALE:										
Box 6876 feath certificate to attending physic	jan/	23b. Was decedent pregnan in the past 12 months?	1 LILIVO D	irth 2 ☐ Feta	ldeath 3	Ectopic pregnancy	,			230	 Date of deli Month 	ivery Day Year
P.O. I	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkno	ant at time of down	ieath 5L	Other (specify)						
ds, P.O. I	by Physician/Med	Part II. Other significant con	nditions contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I		23 <i>e</i> . Did	tobacco use	contribute to	the cause of death?
Division of Vital Records, to attending Physician: The taw requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be control.									10	Yes 2□i	No 3 ☐ Pr	obably 4 Unknown
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ital	BeC	25. Was case referred to me examiner?	-	/				of Death	(Check only	one)		
of V hysic his ce	은	1 ☐ Yes 2 No		·	ER/Outpaties		4 LI NI	- 3	ne 5□Res			cify)
ing P	lo iii	27. Manner of Death 1 ☑Natural 5 ☐ Pe		of Injury th, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2□		8d. Describe	now injury o	ccurred	
iSiC ttend death death stor: , the f	Icat	3 ☐ Suicide 6 ☐ Co	vestigation ould not be 28e Place	of Injury - At h	ome farm st	reet, factory, office	163 2		8f. Location	(Street and I	Number or Ru	ıral Route Number,
Div A after Direct Dire	Certification:	4 ☐ Homicide de		ng, etc. (Specil		ioot, ractory, omoc				wn, State)		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the			tifying Physician: To the									
n 24 l	edical	(Check only 2 Med one)	lical Examiner: On the band man	asis of examina ner stated.	ation and/or in	vestigation, in my o	pinion, dea	ath occurre	d at the time			
vithi To t	Σ	29b. Signature and title of ce	ortifier 2 11)	ho WA	L MD	29c. Licens	1136	.5				7. Day, Year)
		Henry								Havo	ر دما رما	2007
axi		30. Name and address of pe	rson who completed caus	of death (Item	33a) 5Type	Och Rav	un B	Soule	vard	, Batt	imove	MD 21218
s is - Sta	to	31. Date filed (Month, Day,)	(ear) 32_R	egistrar's Signa	ature A					- 11		,
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			State of Maryland / E State of Maryland / E State of Maryland / E State of Maryland / E	epartment of Health and M Certific ate of Death	ental Hygien	2007 09727
	Bhusiai	_	Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physicia /Medio	al		ARd	1.77.	26 Jec7 930 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	lc. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		237-28-1577 10M 28 57	rs. Months Days Hours Min.	December 1	
	and w	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Maryl -f sho	tor	m.D. MA. B	ATT. more		1 □ Yes 2 □ No
	h the	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	ath wit		3211 Vickers Rd.	21216		U.S.A.
	er des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
336	72 hours after death with the Maryland natural', or Items 23a or 28a-f show alcal Examinar must be notified at	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
5-0036	72 hou		15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working		Kind of Business/Industry
2121	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	n	reney Hesp.
	filed w Hygie ther t	e Co	17. Father's Name (First, Middle, Last)	Touse Keefer	(First, Middle, Maid	en Sumame)
404 ylan	ld be ental ked o	o Be	Lekoy morris	Flossi	Ponh	
SLENDA Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Madical Examiner must be notified at once.	-		Mailing Address (Street and Number or Rura		y or Town, State, Zip Code)
~	and 2 ealth a n 27 ls		PAMULA Rich			rough N.C. 27212
NARD, Baltimore,	ges 1 t of H if Itan or oth		Rurial 2 Cremation 3 Removal from State	Disposition (Name of y, crematory or other place)	1-0.7	Location - City or Town, State
WARD, Baltimo	it. Par rtmen rtsnt: njury		4 Donation 5 Other (Specify) 21. Signature of Fureral Service Licensee	22. Name and Address of Facility		Altimore M.).
₩ Ba	Depa Impo sny l		Think hills	22. Name and Address of Facility BETTS - 4 PER	Al HO	3 A 170 MD 21212
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac of	r respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	IC LUNG CANCE	1	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence			19 M CMP43
	- Adminion	76	Sequer tially list non-titions if any, leading to immediate b. Due to (or as a consequence	of):		
H	executed n and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
0,	ite be executed lysicien and ne burial-transit		resulting in death) Last Due to (or as a consequence	of):		
8760,		dicai	d.			
89 x	death certifica attending ph dor use es th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atten affor u	clan	in the past 12 months? Discrete birth 2 Fetal death 1 Voc. 2 Voc. 2 Voc. 2 Voc. 2 Voc. 2 Voc. 2 Voc. 2 Voc. 2 Voc. 2 Voc. 2 Voc. 2 Voc. 2 Voc. 2 V	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.O.	that the de ned by the a detached f	Physician/Med	9 Unknown		_	
	Se Ped	٥	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		2 No 3 Probably 4 Unknown
ord	w requir been si should	eted	TM OF CO.	111A - 2 1 P 1 10		
3ec	e la has je 2	Completed	WHOM? ASSTWANT PULM	3CHO (1) CANE	24a. Was an autopsy performed	
lal	ician: The certificate ha ector, page		25. Was case referred to medical	26. Place of Death	1 Yes 2	No 1 Yes 2 No
>	ysicia Is cert direct	To Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient → ER/Ou	Other		6 ☐Other (Specify)
0	ng Ph fter th ineral			njury Work?	28d. Describe how in	njury occurred
sio	tendii jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	29f Location (Street	and Number or Rural Route Number,
Division of Vital Records,	l or Al	Certification:	4 Homicide determined 28e. Place of Injury - At home, to building, etc. (Specify)	rm, street, factory, office	City or Town, St	
_	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifier (Check only Medical Examiner: On the basis of examination an			
	the H hin 24 the F nplete	Medical	one) and manner stated.	29c. License number		Date signed (Month, Day, Year)
	10 10 10		29b. Signature and title of certifier			
	n		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		E, MD 2120
_			P. VEDAKEB MD 227	ST BAL PL.BI	trum V	E, MO UZO
	Sta		31. Date filed (Month, Day, Year) MAR 2 8 2007 2. Registrar's Signature	Cook)		
	Registi	ell	MAK GO LUUI ARREAD AV.	A CONTRACTOR OF THE PARTY OF TH		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer Month **Physician** WILLIAMS WILLIE MARLH 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER RANDALISTO BALSIMORE NORTHWELK HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** 86 242-24-8958 1920 Warren, Director 23, June Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "neturel", or Items 23a or 28a-f show other treumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Gwynn Oaks Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5226 Pembroke Avenue U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes. Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Heelih and Mental Hygiene. Importent: If item 27 ie marked other then "neturel; or iten eny injury or other treumatic event, the Medical Exacular Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Williams ဨ Sadie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 177 Circle Driveway, Teaneck, Arthur Moss (Brother) NJ 07666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Cooks Chapel Baptist 3/24/07 Warrenton, NC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boyd's Funeral Service Lenn Kellnun P.O. Box 31 Warrenton, NC 27589 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · ARTERIOSCIERDYIL (ARDIDVASCULAR Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Examiner use as the burial-transit Due to (or as a consequence of) ettending physicien Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? (es 2 No 1 Tes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 R/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No efter deeth 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e To the Funeref C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 00024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRBER 5401 DLO COURTRIAD RANDALISTINA CLIFFIND

DHMH 17 Rev 1/2001

State Registrar

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32. Registrar's Signature

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obert Earl Wall		1- For State	State o	f Maryland		nent of cate of		Mental H	ygiene		21	107	0072
		Registrar 1. Decedent's Name	/Eiret Middle Last\		Certific	cate of	Deam		2. Date of De	Reg. No.		3. Time	of Death
Physicia ledical Exami	31 IV	Robert		Ear			Walla		Month March 20	Day 0, 2007	Year	080	9 hrs
		4a. Facility Name (if		street and number)		4	b. City, Town, or Baltimore	Location of Death	ı	4c.	County of D	eath	
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Funeral Director		5. Social Security Nu					Months Days)Fo	oreign Country)	NC
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5-0036 led within 7 Hygiene. other than		17. Father's Name (First, Middle, Last)		<u> </u>			18.Mother's Nam			Surname)		
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Baltimore, MD 21215-0036 Deprnit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 XBurial 2	Cremation 3	Removal from St	crem	natory or oth	ner place)	t Vet 3	3/28/0	7 0	,inas	Mill	ടെ സാർ
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Records, P.O. Box 6876. The law requires that the death certificate cate has been signed by the attending phypage 2 should be detached for use as the l	Phy	Part II. Other signi	ficant conditions		th but not resul	Iting in the u	ınderlying cause	given in Part I.	23e. Di	d tobacco	use contribu	ute to the cau	se of death?
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Dispital ours a neral I	Certification:	4 Homicide	determined	(op ac)									
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 (Check only one)	Certifying Physicia Medical Examiner:	an: To the best of r	ny knowledge, amination and/	death occu	rred at the time, of tion, in my opinic	iate and place, ar n, death occurred	nd due to the o i at the time, d	ause(s) ar ate and pl	nd manner a ace, and due	is stated. e to the cause	e(s)
To th withii To th	Medical	29b. Signature and		and manner stated	1			se number				(Month, Da	
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di		30 No.	ress of person who g	formulated cause of	death /Item 22								
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Regis	trar	IV.	MK & O LUI	UI JULIOUS	W 13.	Page 1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 2^{Day} 200^{Year} 6:15[₽]м Bertha White 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Future Care Charles Village Baltimore NA
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, 12 2 2 2)
 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1□M 2√F Yrs. 219-50-3329 58 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 820 South Caton Ave 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Goodwill Industry Sorter 2th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Almeda Phillips James Grant 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 Hanlon Ave, Baltimore, Md 21216 <u>Vanessa Mack-Bolden</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/28/07 Baltimore, Western Star 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, MD 21215 Approximate Interval Between Onset and Death metastate Due to (or as a consequence of): suns Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performe 1□ Yes 2 NO 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3 DOA

Department of Heath and 2 should be file Department of Heath and Mental Hy, Important: If item 27 is marked other any injury or other framework. **Physician** /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

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o filed within 72 hours after death with Hygiene.

other than "natural", or items 23:

Baltimore, Maryland 21215-0036

Box 68760.

Division or Vital Records, P.O.

Director

Funeral

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that the death certificate be executed Physician; The law requires Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

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31. Date filed (Month, Day, Year)

21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications bot caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No □Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be 1 Yes 2 No 4☑Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D 31464

Registrar DHMH 17 Rev 1/2001 821

ELITAN St Smite 300 BALTIMORE MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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			1 - For Stete Registrar	State of M	laryland /		artmen			and M		Reg. No.	007	097	31
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	Director		220-52-3440 Usual Residence of Decedent		92						April .	11, 1	914 Ma	aryland	
	and ow		10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City	Limits
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	be filed within 72 hours after death with the Maryland ital Hygiene. Is other than "natural", or Items 23a or 28a-f show svent. It e Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.	13.	Vas Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 14	I. Race - Ame Black, White		
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Ē,	item 2		20a. Method of Disposition		20b. Place ceme	of Dispo	sition (Nan	ne of ther place			ate		ation - City or	Town, State	
E	Page sent c nt: If ry or		1 🔀 Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (Sp		Provi					ar 20	6, 2007	Gamb	er Ma	rvland	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service L	censee	1,		. Na <i>me</i> an				824 Rei				
m	Depa fmpo any ir		VELLIA	Man	m	EI	LINE	FUNE	RAL H		Reiste	erstov	wn, MD	21136	
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Division	or Att	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 280. Place of	njury - At home, etc. <i>(Specify)</i>	, farm, str	eet, factory	, office		1	28f. Location (City or To		Number or Ru	ıral Route Numbe	₹r,
	urs al eral D	O	SO- O-HILL A C-AIRLIN	Observation To the base											
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier	and manifel			29c	. License	number			29d. Date	signed (Montl	h, Day, Year)	
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	2		30. Name and address of person w	ho completed cause o	death (Item 23)	a) (Type	Print)	110	-) [117	7 ninsta	5/6	-5/0		
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Registrar

State

Greene Street, Baltimore

Name and address of person who completed cause of death (Item 23a) (Type, Print)

labatabai

31. Date filed (Month, Day, Year)

22

South

32 Registrar's Signature

			1 - For State Registrar	State of Mar	•	epartment of H Certificate of I			ene 007	09733
	Physici		Decedent's Name (First, Middle, La Wanda	M.	Adkins			2. Date of Death Month	Day Year , 2007	3. Time of Death a 8:00 M
A.	/Medic Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or	r Location of Dear	March 9	4c. County of Dea	
	Zxaiiii		612 Ridge Road			Salisbu	ıry		Wicomio	20
	Funeral Director		5. Social Security Number 6.	Sex 7. Age (1 M 2	In yrs. last birth Yı	day) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		o 9. Bir O Ma	thplace (State or Foreign ountry) aryland
	pug M		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town	or Location				10d. Inside City Limits
	f sho	৳	Maryland Wicomi		Salisb					1 AYes 2 No
	with the	Direct	10e. Street and Number 612 Ridge Road			10f. Zip Code 21804		10g	. Citizen of What C	ountry?
۰,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23s or 28s-f ehow any fourty or other traumatic event, the Madical Examinar most be inclified at ances.	Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ■ No	er in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	al', or	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	:	1 ☐ Yes 2 🛣 No	Specify:		Specify:	white
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Decedent's Usual Occup Give kind of work done	during most of wo	orking 16	b. Kind of Business	/Industry
121	within the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired	1)		Labor Ur	nion
10 10	Hygie ther I		17. Father's Name (First, Middle, Las.	_	Adii	inistrator	18. Mother's Na	me (First, Middle, Ma		ITOII
au	d be ental ked o	To Be	Preston Adkins	,			Alice			
Maryland	shound M	-	19a. Informant's Name/Relationship	(Type, Print)	19b. !	Mailing Address (Street	and Number or R	ural Route Number, C	City or Town, State,	Zip Code)
Ž	and 2 alth a 27 is		Alice Adkins/moth	ner	26	66 S. Washir	ngton, U	nit 108, S	now Hill,	MD 21863
Baltimore,	Pages 1.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Makemie	Disposition (Name of crematory or other place Mem. Presidence Cemetery	őy.		c. Location - City of	
Balt	permit. Departrimports any inju		21. Signature of Funeral Service Co			HOLLOWAY	Funeral		essional	Association
1	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line.	e death. Do no					Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a ob.	consequence of):				
	uted d ansit	Examiner	Sequentially list conditions, fary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a d	consequence of	þ.				
,0928	icate be executed physicien and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a o						
9	tificate ng phy as the	ed								
.O. Box	death cer e attendir id for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tin 9□Unknown	Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	olivery Day Year
S, D	0 0		Part II. Other significant conditions	contributing to death but i	not resulting in t	he underlying cause giv	en in Part I.			o the cause of death?
of Vital Record		Completed						24a. Was an autopsy performa	d? death?	utopsy findings available completion of cause of
/ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					ath Check only one		
of \	Physi this o	은	1 Pres 2 No	Hospital:		eatient 3 DOA Oth	4 Nulsing I	Home 5 Residence		ecify)
u C	ding After fune	ou	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Tir	ury Wor	yat k? Yes 2 ∐No	28d. Describe how	injury occurred	
Division	or Attending Phater death. Director: After the in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	28f. Location (Stree City or Town,		lural Route Number,				
_	Hospital 4 hours Funeral ely filled	edical Co	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of a miner: On the basis of ea and manner state	xamination and/	death occurred at the tin or investigation, in my o	ne, date and plac pinion, death occ	e, and due to the cau- urred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and talle procertifier			29c. Licens			Date signed (Mon	th, Day, Year)
1	700	1 1	30. Name and address of person who	200	th (Item 23a) (T	Carroll St	. Sal	Bey w	10325	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature			/		
	Registr		MAR 15	2007 Marie	, H	Grande				
DH	MH 17 Rev 1/2	001			-					

ORIGINAL

1 - For Stata Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILLIAM AMOS /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BODISO If Under 1 Year tahrner Memonal 8. Date of Birth (Month, Day, Year) Birthplace State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F Director 577-42-7548 89 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 MAPLEVILLE ROAD 21713 or items 23a U.S.A. Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinar and. Black, White, etc. 1 X Yes 2 No World 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify <u>چ</u> 3 X Widowed 4 ☐ Divorced Year or Dates: War II WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 SUPERINTENDENT FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILLIAM MANCHESTER AMOS ELIZABETH ANN PICKENS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HOWARD W. AMOS JR/SON 6831 ALLVIEW DRIVE, COLUMBIA, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation SMITHSBURG CREMATORY 3/17/2007 SMITHSBURG, MARYLAND 21. Signature of 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensine Physician Car /Medical ue ld (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit Due to (or as a consequence of) of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day detached for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Sunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 ☐ Yes 2 **5**4 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2500 은 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural death. investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

5H-12

24 hours

To the I

State Registrar

31. Date filed (Mont MARY etr) 5 2007

KHALID WASEEM, M.D.

29b. Signature and title of certifier

4 Homicide

29a, Certifier (Check only one) determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1126 Opal Court, Hagerstown, Maryland Pagistrar's Signatur

1 (**Recritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 (**D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician Buffone** Mar 20, 2007 0050 Samuel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg Frostburg Village Nursing Home Allegany Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Nov 24, 19 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□ M 2□ F Min Hours Months 1918 Director 205-16-9197 88 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or Itema 23a or 28a-f show Ves 2□No Allegany Cumberland MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 12928 N. Cresap St., SW, P.O. Box 1372 USA 21502 death \ Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No IXYes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter ent injury or other treumatic event, the Medical Example and once. 1 Never Married X Married Specify: white 1 ☐ Yes X No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sears Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel F. Buffone Mary Buffone 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100 South Liberty St. MD 21502 **Gregory Skidmore** Cumberland attorney 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Greenwood Memorial Park 3/23/2007 PΑ Lower Barrell 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Juneral Service Licensee Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspi vation neumonia Weeks Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien end for use as the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Strok 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has b lirector, page 2 si autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death | Check only ofe) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No ٥ 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Math 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation 2 🗌 No 1 Tes after death Director: / 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

INB Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: thin 24 hours after der the Funerel Directo impletely filled in by th within To the

Baltimore, Maryland 21215-0036

DR.S.L. 31. Date filed (Month, Day, Year) State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

(i)

29d. Date signed (Month, Day, Year)

TARN TERRACE, FROSTBURG, MD 21532

200

			1 - For State Registrar	State of Ma		epartme Certifica				Reg. N	21111	09736
	Physic /Medi		1. Decedent's Name (First, Middle, L Lenore E. Downs	Bulla					2. Date of Month March	9,	2007	3. Time of Death
) 	Examir Funeral	ner	4a. Facility Name (If not institution, grant Suburban Hospita 5. Social Security Number 6.	1	(In yrs. last birthd	Bet	hesda er 1 Year	Location of		M	ontgomery 9. Birth	7
	Director		Usual Residence of Decedent	1□M 2፟ቚF	94 _{Yrs}	Months.	Days	Hours	Min. 8. Date of (Month,	Day, Yea 5, 1	912 Tenr	place (State or Foreign intry)
	the Marylar 28a-f ehow	ector	10a. State 10b. County MD Montgome 10e. Street and Number		Potomac		ip Code			10- 6	Citizen of What Cou	10d. Inside City Limits ttCtYes 2 □ No
	ath with 23a or	Funeral Director	10714 Tennis Cou			2	0854			Uni	ted State	es
900	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinat must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ver in U.S.	13. Was Dec If Yes, sp 1 ☐ Yes		ispanic Orig in, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ameri Black, White Specify: Whi	
21215-0036	d within 72 h piene. r than "natu the Mudical	Completed	15. Decedent's B (Specify only highest gi) (G	ecedent's Us Rive kind of w fe. DO NOT	rork done i use retired	during most f)		US	Kind of Business/Ir Departme e Treasur	nt of
yland	should be filed on the marked other to marked other to marked other to marked other to marked other to marked other to marked other to marked other to marked other to marked other to marked to marked other	To Be C	17. Father's Name (First, Middle, Las Louis Downs						's Name (First, Midd Le Wallace	lle, Maide		
e, Mar	is 1 and 2 shot Health and Item 27 to m other traum		Barbara Bulla Br		r 953	8 Newb	ridg		Potomac,	MD 2	20854	
altimore, Maryland	it. Page rtment o rtant: If njury or		20a. Method of Disposition 1	fy)	20b. Place of Discemetery, of Arlingt	on Not	erer i one	1 03	Date 3/27/2007 , Joseph (Ar1	Location City or T Lington,	Virginia
Ba	Depa Impo		W. CHI	lung		5130 V	lisco	nsin A	Ave. NW Wa	shin		
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events	b. Dementia C. Chronic	to Thriconsequence of): a consequence of): Obstruc	ve tive F				4.1031,		Interval Between Onset and Death
ς 68760,	The law requires that the death certificate be executed sie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	icai	resulting in death) Last IF FEMALE:	d. Hyperter	consequence of):							
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tis 9 ☐ Unknown	Fetal death	3 □Ectopic 5 □ Other (s				-	23d. Date of deliv Month	ery Day Year
	w requires that been signed I should be det	þ	Part II. Other significant conditions	contributing to death but	not resulting in the	e underlying	cause give	en in Part I.				the cause of death?
Division of Vital Records,	n: The law I ficete has b n, page 2 sh	e Completed	OF Wasses of suid a suid a						pe 1□ Yes	topsy rformed?	prior to co	opsy findings available ompletion of cause of
⋝	sicia s cert lirecto	80	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	aMEDIO.	a	OA Othe	· ·	of Death Check onl			
ō	Phy rathis	. To	27. Manner of Death	28a. Date of Injury (Month, Day)			<u> </u>	7 🗀 . 701.	sing Home 5 ☐ Re 28d. Describ			fy)
ision	Attending Physician: r death. ector: After this certifice by the funeral director; p	Certification;	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Çould not l	on Ope Steep of Injure	1	ry M		(? Yes 2 □ N	lo		and Number or Rur	of Double Alicenter
<u>≥</u>	를 들는 다	i Certii	4 Homicide determined	building, etc.	(Specify)				City or 1	own, Sta	te)	
	To the Hospital within 24 hours a To the Funeral (completely filled	Medicai	one) 2 Medical Exa	hysician: To the best of miner: On the basis of e and manner state	xamination and/or	r investigatio	n, in my o _l	oinion, death	place, and due to the occurred at the time	e, date a	nd place, and due t	o the cause(s)
	30 30		29b. Signature and title of certified	Volue	7	D. 1	D2027			1	tate signed <i>(Month</i> , ch 10, 20	-
	Sta		30. Name and address of person who Kirti Vohra MD 77 31. Date filed (Month, Day, Year)		Blvd. Be		a, MD	2081	7			
	Registr		MAR 1 4 2	007	ALC A	Boarto						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Marjorie Bonfils March 2007 6:05 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Springhouse Manor Care Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Director 81 494-24-2507 1925 July 6, Illinois Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits DC Washington DCXYes 2 □ No Director None 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? United States 20016 4539 Alton Place NW Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Stemm Meta Louis Schiek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Bonfils / Husband 4539 Alton Pl. NW Washington, DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Heaven Cemet 3/17/2007 Silver Spring, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of uneral 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Days **Physician** /Medical Due to (or as a consequence of): Examine Metastatic Lung Cancer Years Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate has 1∐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No ပို 1 🔲 Inpatient 2 ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760 Ö م Division or Vital Records,

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> Daniel V. Young MD // 4530 Connecticut Ave. NW #104 Washington, DC 20008 31. Date filed (Month, Day, Year) 32. State MAR 14 2007 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a, Certifier

(Check only one)

29b. Signature and title of pertitier



🗗 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MD25992

29d. Date signed (Month, Day, Year) March 13, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last. Month **Physician** 3:35 am March 13, 2007 Rosalind E. Bernstein /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Hospice - Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days 1 M 2 X I Yrs Director June 26, 1922 Maryland 217-12-3543 84 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. The Medical Exercises 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 TNO Director Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15101 Interlachen Drive, #706 20906 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔀 No Specify. Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Robinson Jennie Lehman မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 664 Azalea Drive, Rockville, Maryland 20850 Janet M. Gallant - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 3/15/2007 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 21. Signature of Funeral Service Licens e 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner Intestinal Abscess Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -tran and Due to (or as a consequence of): burialphysician s the burial Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 K No 4☐Pregnant at time of death 5 ☐ Other (specify) n signed by the aid be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page this certificate 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice House 1 ☐ Yes 2 🗷 No P funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛘 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

Hospital or Attending

death certificate be executed

Box 68760

P.O.

Division or Vital Records,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) MAR 1 4 2007

Kipithia m Milliams DO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



HO058032

March 13, 2007

			For State Registrar	State of	Marylan		artment of H		and Mental Hy	giene Reg. No.	007	09	739		
er B	Physici	an	1. Decedent's Name (First, Middle						2. Date of De Month	ath Day	Year	3. Time o			
1	/Medic	al	Julie L. Baue				4b. City, Town, or	. Logotion o	Month March 1		007 ounty of Deal	11:40	A M		
	Examin	er	4a. Facility Name (# not institution Wilson Health (-			Gaithers		or Death		ntgomen				
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs!	last birthday)	If Under 1 Year	If Under		th	9. Bir	thplace (State	or Foreign		
	Director		219-94-1356	1 ☐ M 2 🖾 F	86	Yrs.	Months Days	Hours	Min. (Month, Da May 31,	1920	Wash	ington	, DC		
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	v. Town or Lo	ocation					10d. Inside C	ity Limits		
	Maryli f sho	ō	Maryland Montgo		Coi	thersb	11120					1X Yes	2 No		
	r 28e-	rec	10e. Street and Number	omery	Gai	.theist	10f. Zip Code			10g. Citize	on of What Co	ountry?			
	th with	alD	301 Russell Ave	enue #315A			20877			Unite	d Stat	tes			
	r dea	ıner	11. Marital Status	12. Was Deced Armed Force	es?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Ori in, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)	D- 14	Race - Ame Black, Whit				
36	or if	by Funeral Director	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes Give			1 ☐ Yes 2 🛣 No	Specify:		S	Specify: Whi	Lte			
9	72 hours after death with the Maryland natural; or itema 23a or 28a-f show alsai Examinant be notified at		15. Deceden	it's Education		16a. Dece	dent's Usual Occupa	ation		16b. Kind	d of Business	/Industry			
215	within 72 ene. than "n	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4	lor 5+)	(Give	kind of work done of DO NOT use retired	during mos d)	t of working						
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and	ntal H	Be	17. Father's Name (First, Middle, Charles Sewell	*					er's Name <i>(First, Middl</i> e iece Mayhew						
Maryland 21215-0036	2 should be and Mental is marked raumatic ev	ဥ	19a. Informant's Name/Relations			19b. Mailir	na Address (Street a		er or Rural Route Numb			Zip Code)			
	nd 2 suith ar		Eric Bauer / So				-		ckerson, MI			, ,			
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Baltimore,	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeran Service	Licensée					yĴoseph Gaw Ave. NW Was						
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×	/Medical Examiner		. Joseph J. J. J. J. J. J. J. J. J. J. J. J. J.												
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	cate be executed obysicien and the burial-transit	Examiner	that initiated events	S											
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Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birt	h 2 □ Feta nt at time of d	Ideath 3[Ectopic pregnancy Other (specify)	·		20	Month	Day	Year		
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o	ding Phys h. After this funeral di	-	27. Manper of Death	28a. Date of		28b. Time o			28d. Describe			ecity)			
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Division of Vital Records,	or Attenation deat Director: In by the	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of	f Injury - At he , etc. (Specif	ome, farm, st	reet, factory, office			(Street and wn, State)	Number or R	lural Route Nut	nber,		
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	>		30. Name and address of person	who completed cause	of death (Ite	23a) (Type,	Print) 2011	us	58114081	VUE	1 -	DOL			
-			31. Date filed (Month, Day, Year		gistrar's Signa	ature	CHT	748,	RSBURG,	MIG	La	77			
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			For State	State of N	Maryland		artment of H		d Mental H	Hygiei	ne	00-	0071
1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician (Medical CHARLES LORENZ BURTON										Reg.	No.	UU/	3. Time of Death
				· · ·				Month M A R		Day /a	2007	2258 M	
	/Medic Examin	A 100	4a. Facility Name (If not institution		er)		4b. City, Town, or		eath	7		ty of Death	-
	a facilities and	\$			DSPITT			4570A			7	ALL	
	Funeral Director		5. Social Security Number	6. Sex 7 1	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Day, Ye	ar)	Coun	lace (State or Foreign try) YLAND
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2	hours tural" al Exa	ed by	3 Widowed 4 Divorced	Year or Date It's Education	es:	16a Deced	ient's Usual Occup	ation		16b	1-36	WHI!	
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_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	1 1	(Check only 2 Medical	ng Physician: To the be Examiner: On the basi	est of my know	wiedge, deat tion and/or in	h occurred at the till vestigation, in my o	me, date and p	lace, and due to	the caus	se(s) and r	manner as s e, and due to	tated. o the cause(s)
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0	+VA)		30. Name and address of person	- A		23a) (Type,	Print)	Toshn	52 , MD		216	10	
	Sta		31. Date filed (Month, Day, Year,) Reg	V √) gistrar's Signa	ture			, ,/	atc	10		
	Registr	ar	MAR 14	LUU/	AT.	1							

			For State Registrar	State of M	larylan		artment of F		and Me		giene Reg. No.2	07	09741		
A	9		1. Decedent's Name (First, Middle	e, Last)					2	2. Date of Dea	ath Day	Year	3. Time of Death		
E.	Physicia /Medic		Juanita	Louise	Bea	itty				March					
	Examin		4a. Facility Name (If not institution	, give street and number	-)		4b. City, Town, o	r Location o	of Death	4c. County of Death					
100	in a	10.	1430 Knight Ave				Dunki		O4 Um Ta	Calvert					
94	Funeral Director		5. Social Security Number 577–62–5490	6. Sex 7. A	.ge (<i>In yrs.</i> . 61	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birtl (Month, Day Dec 25,	y, Year)	Coui	place (State or Foreign htry) t Virginia		
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	with a or t be r		1430 Knight Ave	anuo.			20754	l			10g. Citizen of What Country? USA				
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9	or ite	Ē	1 X Never Married 2 ☐ Marr	Armed Forces ied 1 ☐ Yes 2 ☑ If Yes, Give		13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						ck, White,	etc.		
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Baltimore,	Pages nent of I ant: If Ite		1 X Burial 2 ☐ Cremation		е С	emetery, cre	matory or other pla	i i				•			
Ħ	교 는 은 등		4 □ Donation 5 □ Other (Specify) So. Memorial Gardens 03-14-2007 Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility												
Ba	Depar Impo any Ir once,		William	R. Gre			Rausch Fi		-	e, P.A.	, Owing	gs, M	D 20736		
h			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the deat line.	h. Do not en	ter the mode of dyin	ng, such as	cardiac or	respiratory ar	rrest,		Approximate Interval Between		
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	requires that the een signed by th nould be detache	by Pl	Part II. Other significant condition				nderlying cause giv	en in Part l		23e. Did to	obacco use con	tribute to t	he cause of death?		
ord	n requires been sign should be		Hypertensi	ve Heart	Dise	ase				101	Yes 21 No	3 ☐ Pro	bably 4 □Unknown		
or Vital Records,	law as b	Completed	Diabetes							24a. Was			opsy findings available ompletion of cause of		
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Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			ot 3000 Oth			Check onli					
ō	Phys r this ral dii	- To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpa 28a. Date of In		ER/Outpatie	IL SUIDOA	4 🗆 NL			dence 6 Otl		fy)		
OU	Attending r death. ector: After by the funer	ţi	1 X Natural 5 ☐ Pendin 2 ☐ Accident investi	g (Month, E	day Year)	Injury	Wor	rk?ົ ∣Yes 2∐		000011201	now injury cood	,,,,			
Division	or Attendatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could determ	ined 200. Place of I	njury - At ho etc. <i>(Specil</i>		reet, factory, office		28	Bf. Location (S City or Tov	Street and Num	ber or Run	al Route Number,		
Ö	tal or rs afte at Dir led in	Cert			etc. (opecn	<i>y</i> /			ju	City of You	wii, State)				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the bes Examiner: On the basis and manner:	of examina	wledge, dea ition and/or in	th occurred at the ti evestigation, in my	me, date ar opinion, dea	nd place, ar ath occurre	nd due to the d at the time,	cause(s) and m date and place	anner as s and due t	stated. to the cause(s)		
	To the within 2 To the сощре	Me	29b. Signature and title of certifie		0		29c. Licens	se number			29d. Date signe	ed (Month,	Day, Year)		
			Karal	uto 7 cm	1 la		D00	5553	9		March	14,	2007		
	IK		30. Name and address of person												
			Eugene Taylo	or, M.D.	5100	Auth	Way, S	uitla	and,	MD 20	0746				
	Sta Registi			1 5 2007	A Sepa	Auch ature	Ande	9							

			1 - For State Registrar	State of	Maryland		artment of F rtificate of		d Mental Hy	rgiene Reg. No?	7	ng71.2	
	Physici	an	Decedent's Name (First, Middle, La	*	ot Ann I	Brasser			2. Date of De Month	eath Day	Year	3. Time of Death	
-	/Medic	cal	4a. Facility Name (If not institution, giv		et Ann I	browr	4b. City, Town, o	r Location of D		ar 9, 2007	of Death	1848 M	
T.	LXanını	161		norial Hospit				ince Frede			Calv	ert	
ĺ.	Funeral Director		5. Social Security Number 6. S 216-70-3458	Sex 7 I□M 2X1F 7	. Age (In yrs. la: 49	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Ain. (Month, Da	irth 9. Birthplace (State or Foreign Country) 5, 1957 Maryland			
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits	
	e Mary ia-f sho tified a	ctor	MD Anne	Arundel				Lothian				1 □Yes 2X No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show amy fijury or other traumatic event, the M-dical Examiner must be notified at once.	by Funeral Director	10e. Street and Number 214 B Street				10f. Zip Code	20711		10g. Citizen of W	hat Cour	•	
	r death	nera	11. Marital Status	12. Was Deced Armed Ford		. 13. V	Vas Decedent of F f Yes, specify Cub	lispanic Origin' an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	0- 14. Race	- Americ	an Indian,	
980	urs afte al"; or It	by Fu	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4本 Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat		- 1	□Yes 2X No	Specify:			Black		
2-0	"natur dical E	leted	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	ent's Usual Occup kind of work done	during most of	working	16b. Kind of Bus	siness/Ind	dustry	
21215-0036	d withir giene. er than the M	Completed	Elementary/Secondary (0-12)	College (1-4	for 5+)	IIIe. L	Day Car	^{a)} e Provider		D	ay Ca	re	
	should be filed vand Mental Hygies marked other tumatic event, th	Be	17. Father's Name (First, Middle, Last	Edward P	indell			18. Mother's	Name (First, Middle Aane	, Maiden Surname es Isabel Burl	,		
Maryland	should and Me smark	오	19a. Informant's Name/Relationship (r Rural Route Numb	per, City or Town, S		Code)	
	1 and 3 Health em 27		Rose Pindell /Sister 20a. Method of Disposition	<u> </u>	20b. Pla		Woodhill Driv sition (Name of natory or other pla		Irnie, MD 210	61 20c. Location - 0	City or To	wn State	
Baltimore,	Pages nent of int: If it		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		ate cer		natory or other pla Cemetery		03/17/07		thian,		
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service Lice	leswell	0	22		ıneral Hon	ne Road Prince F	rederick MI	2067	78	
p	* * * *	1970	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	used the death.	Do not ente					2001	Approximate Interval Between Onset and Death	
No.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	r as a conseque		Eml	olism			-	Onset and Beath	
	Examiner		Sequentially list conditions,	b									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events	Due to (or	r as a conseque	ence of):							
90,	ficate be executed physician and is the burial-transit	I Exa	resulting in death) Last	Due to (or	r as a conseque	ence of):		_					
68760,	ifficate I g physia as the k	edical		_d									
Box	leath certific attending p	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2 Fetal d	leath 3	Ectopic pregnanc	/		23d. Date		ery Day Year	
o.	ires that the de signed by the a I be detached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnai 9∏Unknow	nt at time of dea n	ath 5∟	Other (specify) _					Ju,	
ds, P	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use a	by	Part II. Other significant conditions of	contributing to dea	th but not resulti	ing in the un	derlying cause giv	en in Part I.		tobacco use contri Yes 2 No :		ne cause of death?	
Records,	aw require s been się s should b	Completed	Coxxx	VED4	Lutes	T)1 Secre			an 24b. W	ere auto	psy findings available	
	ician: The lav certificate has rector, page 2	Com		3		7			— auto perfo 1□ Yes	ormed / de	eath?	npletion of cause of 2 No	
· Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examinar? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Ing	patient 2 D	R/Outpatient	3 DOA Oth	Or:	Death <i>(Check only only of the control of the cont</i>		r (Cnooih	w)	
o u	ing Affer une	on: T	27. Manner of Death 1 ▶Natural 5 □ Pending	28a. Date of (Month,		8b. Time of Injury	28c. Injui Wor	y at k?		how injury occurre		<i>,,</i>	
Division or	Attend r death ector: / by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of	f injury ~ At hom	e, farm, stre	M 1 ==	Yes 2 No	28f. Location (Street and Numbe	r or Rura	l Route Number,	
ā	oltal or urs afte eral Dir				, etc. (Specify)				City or To				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☐ CertifyIng Pt (Check only one) 2 ☐ Medical Exam	nysician: To the b miner: On the bas and manne	is of examination	edge, death on and/or inv	restigation, in my	me, date and p opinion, death o	lace, and due to the occurred at the time	cause(s) and mar , date and place, a	ner as st nd due to	tated. the cause(s)	
1	To t To ti	ž	29b. Signature and title of certifier	0160			29c. Licens	e number		29d. Date signed	(Month,	Day, Year)	
	Λ		30. Name and address of person who	completed cause	of death (Item 2) 3a) (Type, i	Print)	7321	4	3110/0) /		
	d		Raymon Nable 31. Date filed (Month, Day, Year)		gistra Signatu	Daer	Rome	+, Hu	intest	awn, r	ND	20639	
	Sta Registr		MAD 1	4 2007 ▶	John and	K	Books	,	3	,			

		FOI	partment of Health and I ertificate of Death	Mental Hygien	2001 00144
	sician edical	1. Decedent's Name (First, Middle, Last) William Merritt BROWN		2. Date of Death Month March 15,	2007 Year 3. Time of Death 10:40p. M.
	miner	4a. Facility Name (If not institution, give street and number) Homewood Nursing Home	4b. City, Town, or Location of Death Williamsport	4	4c. County of Death Washington
Funei Direct		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 № M 2 ☐ F 88 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea March 2,]	9. Birthplace (State or Foreign Country) New York
aryland	,	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Washington William			10d. Inside City Limits 1 □ Yes 2∑ No
vith the M or 28e-f	Director	10e. Street and Number 16837 Hampton Road	10f. Zip Code 21795	10g. (Citizen of What Country?
leath v ne 23e	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	U.S.A. 14. Race - American Indian,
urs after of iter	by Fun	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White, etc. Specify: White
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I emarked other than "naturel; or iteme 23a or 25e-1 ehow sunnatic event. Its Model Executation to the metallic and the results of the profile of the contraction of the profile	Completed	15. Decedent's Education (Specify only highest grade completed) (Gi life Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of wor n. DO NOT use retired)	rking 16b.	Kind of Business/Industry
led wit tygiene her tha	Co	12 5+ Ord	ained Minister	/First Maintale Maria	(ag Cumana)
id be fill be fill be fill be fill be fill be ked ot	To Be			ne <i>(First, Middle, Maidl</i> Jean P. Ki	
2 should and Men ie marke sumatic		19a. Informant's Name/Relationship (Type, Print)	tiling Address (Street and Number or Ru	ral Route Number, City	y or Town, State, Zip Code)
1 and 1 and Health em 27			37 Hampton Road, W	The second second	t, Maryland 21795 Location - City or Town, State
Pages nent of I			position (Name of rematory or other place) Own Crematory 20	h 17.	gerstown, Maryland
permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke eny injury or other traumatic.	once	21. Signature of Funeral Service Licensee	22. Name and Address of Facility M	innich Fun	
Physicia /Medic		23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Sest and Death
icate be executed physician and physician and si the burial-transit	E è	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):			
Livision of Vital Index 1997, T.C. DOX 00 100, Within 24 hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic		3 ⊟Ectopic pregnancy 5 ⊡ Other (specify)		23d. Date of delivery Month Day Year
uires that uires that signed bi	d bv P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
The law requested that the second that the sec	Completed			24a. Was an autopsy performed	
veician reician s certifi	To Be	examiner?	Othor	th (Check only one)	6 Other (Specific)
ding Phy th. : After this	tion: T		of 28c. Injury at	28d. Describe how in	
al or Atter s after dea il Director	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Hospit 24 hours Funera	Medical		ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause irred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the Within To the	Me	29b. Signaluga and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type	Per-Print) (4) 5	116/200)
122+		STEDHENE METENEN (A) 13424	13 Ave, It rask	stown, lu	43(782
	State istrar	31. Date filed (Month Cay, Year) 2007	Sperke		

			For State Registrar	State of Maryland		artment of F ctificate of t			jiene leg. No.? ()	07	00715
			Decedent's Name (First, Middle, Last)	·				2. Date of Dea Month		Year .	3. Time of Death
	Physici /Medic		 	urgess				3	11 2	007	giogers. M
	Examin	ner	4a. Facility Name (If not institution, give: Baltimore Washingt		iter	4b. City, Town, or Glen But	r Location of Death			ty of Death Arunde	1
	Funeral		5. Social Security Number 6. Sec			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birthpla	ce (State or Foreign
	Director		099-00-000	^{1M 2} ∑F 52	Yrs.	Months Days	Hours Min.	Nov 4,	1954	New Y	ork
land	t t		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				100	d. Inside City Limits
Mary	a-f sho	tor	MD Anne Arun	del Gler	ı Burn	ie					1 ☐ Yes 2 ☐ No
ith the	or 28	Director	10e. Street and Number			10f. Zip Code	-		10g. Citizen of	What Country	y?
eath w	is 23a nust t	eral	1011 Stane Road	12. Was Decedent Ever in U.S	12 \	21060	lispanio Origin? (Sr		JSA 14 Ba	ice - American	n Indian
ufter de	r item	Funeral	11. Marital Status 1 □ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Bla	ack, White, etc	
Nours a	ıral",o Exan	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Speci	Whit	е
n 72 h	"natu edica	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Deced (Give life, L	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work d)	ting	16b. Kind of E	Business/Indu	stry
with A	r than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ess Owner			Accoun	ting	
allo filec	al Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam			ime)	
aryiarid x1x13-0030 should be filed within 72 hours after death with the Maryland	d Ment narke natic e	٩	Robert Ruffell	D-i-d	105 11-11	Add (Ctt	Rosemary			- 01-1- 7:- 0	2-1-1
Man Man	Ith and 27 is n traun		19a. Informant's Name/Relationship (Ty Terry Burgess/husb				and Number or Ru ad Glen B				oae)
s 1 ar	item (20a. Method of Disposition	CC	L ace of Dispo emetery, crer	sition (Name of natory or other place	ce)	Date	20c. Location	- City or Tow	n, State
Dallillo	ment ant: If		1 ☐ Burial 2 ☐ Tremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emovat from State I	sapeak	e Cremato	ory 03/1		Beltsvi		
Dall Dermit.	Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	1 1 11			ss of Facility Cremati				
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or				Heckrot ng, such as cardiac				Approximate Interval Between
Ph	ysician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	1 +	1.	us Cam			Č	Interval Between Onset and Death
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nted	Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2	0 0 4 1	11.2.					
C,	an and rial-tra	Еха	resulting in death) Last	Due to (or as a consequ	ence of):	<u> </u>					
cate be executed	physician and s the burial-transit	dical		1							
OX O	ding p se as	/Med	IF FEMALE:	3c. If yes, outcome pf pregnar	ncv				23d D	ate of delivery	
death	e atten d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No	1□Live birth 2□Fetal 4□Pregnant at time of de	death 3□	Ectopic pregnancy Other (specify)	<i>'</i>		l .	,	y Day Year
at the	by the	hys	9 ☐ Unknown	9∐Unknown							
ires th	signed I be de	þ	Part II. Other significant conditions co	ntributing to death but not resu	lting in the u	nderlying cause giv	en in Part I.		ibacco use coi ′es 2 No		cause of death?
cords, w requires t	been	Completed						24a. Was a			sy findings available
The lay	te has age 2	dmo						autop		prior to comp death?	pletion of cause of
VII de l'ocian:	ertifical ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Dear			1 ☐ Yes 2	⊇□ No
Of v Physic	this ce	To E	1 ☐ Yes 2 ☐ No		R/Outpatier		4 ☐ Nursing H	ome 5 ☐ Resid			
SIOI C	After funera	ion:	27. Manner of Dath 1. Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2∐No	28d. Describe h	ow injury occu	urred	
Atten	r deatl ector: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, str			28f. Location (S	Street and Nun	nber or Rural I	Route Number,
Z ela	rs affe ral Dir led in	Cert	4 Ditionicide	building, etc. (Specify	/			City or Tow	ni, Siale)		
Hospi	24 hou Funer fely fill	Medical		sician: To the best of my knowner: On the basis of examinat							
UNUSION OF VILGI DECOLUS, P.O. BOX of the Hospital or Attending Physician: The law requires that the death certifications	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	29d. Date sign	ned (Month, Da	ay, Year)
)			1 Jayashree	Auble M.	D	0	46596		3	11/07)
102			30. Name and ad uss of person who co		23a) (Type,		. Harl -		1 7	1100	h-t-0 l
		ate.	JAYASHREE A 31. Date filed (Month, Day, Year)	MRLE Bold 32. Resistrar's Signat		. washingt	or Mos be	tal cen	the . 30	0.1-	pital due
	Sta Registr		MAR 1 4 2	nn7 Been	K.	Para Maria				Ju	ment of

			1 - For State Registrar	State o	f Marylar		artment rtificate				lental Hy	gien	2001	097	46
1	Physici	an	Decedent's Name (First, Middle								2. Date of De. Month		ay Year	3. Time of	Death
	/Medic			Richard	Lee Ba	rnett					March	20		0850	A ^M
	Examin	er	4a. Facility Name (If not institution		mber)				Location of	of Death		40	c. County of Deat	h	
	**	142	Laurelwood Ca					kton					Cecil		
п	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birl (Month, Da	h y, Year		hplace (State o	
- Air	Director		159-28-2087 Usual Residence of Decedent	A	88	110.					March 9	, 19	919 Nor	th Caro	lina
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside Ci	ty Limits
	Many a-f-et	tor	Maryland Ceci	1	E	1kton								1 ☐ Yes	2 X No
	h the	Directo	10e. Street and Number		1	<u> </u>	10f. Zip	Code				10g. C	itizen of What Co	untry?	
	23a c		911 Kirk Road				2	1921					United S	States	
	dea me	by Funerai	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U		Was Deced	ent of Hi	spanic Original	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White	nican Indian,	
98	or it	y Fu	1 Never Married 2 Marr		2 🕅 No		1 ☐ Yes 2		Specify:		r 110a11, 610.)		Specify:	e, etc.	
8	ural',	d D	3 Widowed 4 Divorced	Year or D	ates:								W	hite	
5	filed within 72 hours after death with the Maryland thygiene. ther then "natural", or itame 23e or 28e-f ehow thit, the Medical Examinar must be rodified at	Completed	15. Decedent (Specify only highes			(Give	dent's Usua kind of wor DO NOT us	k done a	lu <i>ri</i> na mosi	t of work	ing	16b. i	Kind of Business/	Industry	
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0	filed Hygi Sther	ŭ	17. Father's Name (First, Middle,	Last)		GI	ower		18. Mothe	er's Name	(First, Middle,		rticultı n Sumame)	ire	
an	id be ental ked c	To Be	Chrisenberry	Barnett					H11 1	da E	dwards		,		
Maryland 21215-0036	shou nd M mar	_	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a				er, City	or Town, State, Z	Zip Code)	
	alth a		Carol Parsons/D	aughter-i	n-law	911	Kirk H	Road	. Elk	ton.	Mary1a	ind	21921		
Jre,	s 1 a of Hea itam		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	e of			Date		ocation - City or	Town, State	
E	Page nent c int: if		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State Gr	acelawi	n Memo	ria		2007	23,	New	Castle	Delaws	are
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itame 23s or 28s-f ehow way injury or other traumatic event, the Medical Examination and page.		21. Signature of Funeral Service	_icensee	. 4.33	22	2. Name and	Addres	s of Facility	v					
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			23a. Partt. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the deat	h. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory ar	rest,	,	Approximate Interval Bety	e ween
Electric Control	Physician		Immediate Cause (Final disease or condition	Service and	50	ENE	1200	100	24					Onset and E)eath
	/Medical Examiner		resulting in death)	Due to (or as a conseq				ev.)						
Н	LAdilinier		S quantially list conditions if any, leading to immediate	b	Dre	unor	M								
	ed sit	Jine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or s a conseq	juence of):	lan.		,						
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or s a conseq	uence of):	FLU	SLess	~	_					
8760,	Attending Physician: The law requires that the death certificate be executed redeath. redeath. cotor: After this certificate has been signed by the attending physician and yothe funeral director, page 2 should be detached for use as the burial-transit.	icai E			6.										
189	ficate p phy as the	e e		0.											
Вох	eath certific attending p	NA M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			-						23d. Date of deli	verv	
œ.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn	irth 2 ☐ Feta ant at time of d]Ectopic pre] Other <i>(spe</i>						Month	Day Y	'ear
P. O.	by th	Physician/M	9 Unknown	9□ Unkno	own							İ			
	res that the de signed by the a be detached f	by	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco	use contribute to	the cause of de	eath?
Records,	w require been si should b										1 🗆 Y	es 2	Pro 3 □ Pro	obably 4 DI	nknown
ec	e law r has be je 2 sh	Completed									24a. Was autop			topsy findings a	
<u></u>	ysician: The is certificate hidirector, page	Con									perfor	rmed?	death?	No No	1036 01
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?					_		of Death	Check only or	ne)			
5	Physi this c al dire	٩	1 Yes 2 No		npatient 2				INUI	rsing Ho	me 5□Resid	lence	6 □Other (Spec	cify)	
Division of Vital	ding P. h. After funera	Ö	27. Manner of Peath L□Natural 5 □ Pending		of Injury th, Day Year)	28b. Time of Injury		lc. Injury Work			28d. Describe h	low inju	iry occurred		
S	death ctor: / the	licat	2 Accident investig 3 Suicide 6 Could n	01/e 00/Diam	of Injury - At he	ome farm str	M net factors	_	′es 2 □ N	-	28f Location /S	Stepot a	nd Number or Ru	m / Pouta Mumb	
<u> </u>	i gitte	Certification:	4 Homicide determi		ng, etc. (Specif	y)	col, ractory,	Onice			City or Tow			rai Addie Norri	ier,
	spita nours neral		29a. Certifier 1 Certifin	g Physician: To the	best of my kno	wledge, death	n occurred a	t the tim-	e, date and	d place, a	and due to the o	cause(s	and manner as	stated.	
	To the Hospital or within 24 hours after to the Funeral Director Completely filled in	edicai	(Check only 2 Medical E	xaminer: On the ba	asis of examina	tion and/or inv	estigation,	in my op	inion, deat	th occurre	ed at the time, o	date an	d place, and due	to the cause(s)	
	To the Hospital within 24 hours a To the Funeral Completely filled	×	29b. Signature and title of certifier				29c.	License	number			29d. Da	ate signed (Monti	n, Dey, Year)	
}) / ///.				$ \mathcal{L} $	175	0/3	>		1	LNIAR	01	
	2	Ì	N 14-	who completed caus	e of death (Item	n 23a) (Type,	Print)		. ,	701	11	,	2 MAR 37 CE L) _ le	270
			ARIEN 67	DUE IN	vs 6	517 61	nech	wa) رد	JIL	NO	JU	37 LE 1)E	1720
# 15 mg	Sta Registra		31. Date filed (Month, Day, Year) MAR 2 8 2	007	egistrar's Sigra	iture goza	W								

Λ7	-02080	١
U/	·UZUQL	,

Physician/ dical Examiner 1. Decedent's Name (First, Middle,Last) RICHARD BLANE BARLOW, JR. 2. Date of Death Month Day March 16, 2007 4a. Facility Name (if not institution, give street and number) 13495 Budds Creek Road 4b. City, Town, or Location of Death Charlotte Hall Charles Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Exception) Contains	hard Blaine Bar	1	r, Jr. State of Maryland / Department of For State Egistrar State of Maryland / Department of Certificate of		Mental Hy	rgiene Reg.	No. 20	07 09747		
1.3496 BUILDO CREEK ROAD 100 City Town to Location 1.00 City Town town to Location 1.00 City Town town to Location 1.00 City Town town town town town town town town t	Physician/ edical Examine	7 1	. Decedent's Name (First, Middle,Last)			Month D	yay Year 007			
Distriction The second of the property of the		4	, , , , , , , , , , , , , , , , , , , ,					f Death		
Date Date								9. Birthplace (State or Foreign CountryMARYLAND		
13495 BUDDS CREEK ROAD 20.622 U.S.A. 1.1 Minuted Status 1.2 M	È .		0a. State 10b. County 10c. City, Town or Locati		ΔΤ,Τ,					
21. Signature of Fureral Service Loorsee MOO 4/9 22. Same and Address of Facility RAYMOND FINERAL SERVICE, P.A. The Proposition of the Property of Service Loorsee MOO 4/9 23. Same and Address of Facility RAYMOND FINERAL SERVICE, P.A. Approximate Interval Between Oriset and Death Modical Examiner Approximate Interval Between Oriset and Death Modical Examiner Approximate Interval Between Oriset and Death Death Death Color as a consequence of): Sequentially list conditions, S	larylanc				722	10g.	. Citizen of Wh	at Country?		
21. Signature of Fureral Service Loorsee MOO 4/9 22. Same and Address of Facility RAYMOND FINERAL SERVICE, P.A. The Proposition of the Property of Service Loorsee MOO 4/9 23. Same and Address of Facility RAYMOND FINERAL SERVICE, P.A. Approximate Interval Between Oriset and Death Modical Examiner Approximate Interval Between Oriset and Death Modical Examiner Approximate Interval Between Oriset and Death Death Death Color as a consequence of): Sequentially list conditions, S	h the M 3a or 2 otified									
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21. Spranurs of Fundam Service Locases or complements that causes the geath Do not end frith model of Land Land Land Color of Course and District Course and District Color of Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and Dis	36 nin 72 hours aff than "natural" dical Examine	દ⊩	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	t's Usual Occupationst of working life. I	n (Give kind of w		ELECTRICAL UNION			
21. Spranurs of Fundam Service Locases or complements that causes the geath Do not end frith model of Land Land Land Color of Course and District Course and District Color of Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and District Course and Dis	be filed with small Hygiene rinked other i vent, the Me	a	7. Father's Name (First, Middle, Last) RICHARD BLANE BARLOW, SR.		CECILI	A MARIE	E KURZ			
21. Sprawur of Funerial Service Locates MO 0 49 Part Enter the disease, or completer/s that caused the gealth point and provided the first provided by the service of t	MD 21 and 2 should salth and Me em 27 is ma raumatic ev		CHARLOTTE M. BARLOW-WIFE 13499	BUDDS	CREEK	RD., CHA	ARLOTT	E HALL, MD206		
Physician Medical Families List only one cause on each line. 29 Part Enter the disease, or completends that caused the death Do not ender fine model of syndy, such as death of the course of seath o	Saltimore bernit. Pages 1 a Department of He mportant: If it njury or other t		1 Burial 2 X Cremation 3 Removal from State crematory or oth 4 Donation 5 Other Specify: METROPOLITIA	ner place) AN CREMA	ATORY 3					
UNPENDED Tarry Sed in a consequence of	/Medical		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Sharp Force Injuries Due to (or as a consequence of):	ne mode of dying, s	uch as caldide o	Tespiratory artes	F, shock, or hea	Between Onset and		
The part of the pa	d ansit	Examiner	f any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated			-21				
The part of the pa	cian and	dical	UNPENDED AMENDED							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	Sox 68760 death certificate the attending physical for use as the bu	ysician/Me	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fe Pregnant at time of death 5 0t		ancy					
5 295. Signature and title of certifier O.C.M.E. March 17, 2007 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	P.O. E res that the signed by the be detached	2	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause gi	ven in Part I.		2 No 3	Probably 4 Unknown		
5 290, Signature and title of certains O.C.M.E. March 17, 2007 30, Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Records The law requi	omplete				autopsy perform	/ F	orior to completion of cause of death?		
5 29b. Signature and title of certifier O.C.M.E. March 17, 2007 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	cian: Certific		eyaminer?		Othor			A Other Seen		
5 290, Signature and title of certifier O.C.M.E. March 17, 2007 30, Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	n of Vi ading Physi th :: After this e funeral di	- 1	1	Injury 28c. Injury	y at Work?	28d Describe ho	w injury occurr	red		
5 295. Signature and title of certifier O.C.M.E. March 17, 2007 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Divisic or Atte urs after dea ral Director lled in by th	ertifical	3 Suicide 6 Could not be determined (Specific) Single Family	et, factory, office bu	uilding, etc.	28f. Location (St or Town, Sta 13495 Budds C	reet and Numb ate) Creek Road, (er or Rural Route Number, City Charlotte Hall, MD		
5 290. Signature and title of certifier O.C.M.E. March 17, 2007 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	the Hosp iin 24 hou the Fune ipletely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occuone) 2 Medical Examiner: On the basis of examination and/or investigations.	rred at the time, da tion, in my opinion,	te and place, and death occurred	d due to the cause at the time, date a	(s) and manner nd place, and c	r as stated due to the cause(s)		
Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To I with To I com	Med	and manner stated.	29c. License	number		29d. Date sign	ed (Month, Day, Year)		
	5	_	Pamela E. Southall, MD Assistant Medical Examiner 1	1 Penn Street	, Baltimore, I	MD 21201				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Pau1 03 2007 0121 **Blacker** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WMHS - Memorial Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 5, 1941 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday. 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min 1 M 2 □ F МD Director 214-36-7074 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f sh dical Examiner must be notified 1 □Yes 2□No WV Mineral Ridgeley Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26753 USA Rt. 1 Box 400 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes ≥ □ No If Yes, Give Year or Dates: Vietnam 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ XIo Specify Specify. þ 3 ☐ Widowed 4 ☐ Divorced white Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CSX 12 trackman 12 should be filed w h and Mental Hygier 7 Is marked other th or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o any injury or other trainment Anna I. Harbaugh Blacker William A. Blacker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WV 26753 wife Rt. 1 Box 400 Ridgeley Rita Blacker 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 3/22/2007 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Cerebrovascular accident **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Por in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ed by the a I□Yes 2□No P.0. 9□Unknown 9 Tinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an has autopsy performed? res 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2N No 1 Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

3

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 8 2007

UMBERLAND

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State Registrar		State of M	laryland		artment rtificate			ind M	lental H	ygie Reg.	201	17	09749
	Physici		1. Decedent's Name (First, Mi									2. Date of I Month		Day 2007	Year 7	3. Time of Death 7:30 P M
	/Medic Examin		4a. Facility Name (If not institu			r)		4b. City,	Town, or	Location o	f Death	12011		4c. County		1
	Exami		Anne Arundel	Med	ical Cen	ter		Anna	apo1					Anne .	Aru	ndel
	Funeral		5. Social Security Number	6. 5	Sex 7. A 1 □ M 2 💢 F	ge (In yrs. las		If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of I	Birth Qay, Yo	ear)	9. Birth	place (State or Foreign intry)
	Director		162-26-3723 Usual Residence of Decedent		ZAI	73	Yrs.					OCT.	25,	1933	Per	nŝylvania
	land ow		10a, State 10b. Cou	nty		10c. City,	Town or Lo	cation				-				10d. Inside City Limits
	Man,	tor	MD Anne	Ar	undel	Cr	coft	on								1 ☐ Yes 2 X No
	or 284	Director	10e. Street and Number			<u>'</u>		10f. Zip	Code				10g	. Citizen of V		untry?
	ath wi		1802 Log	M:					1114					U.S.		
36	n 72 hours after death with the Maryland "natural", or Items 23e or 28a-f show calcal Ester if retribust be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☒ Divore		12. Was Deceder Armed Forces 1 Yes 2 2 If Yes, Give Year or Dates	s? 【 No		Was Deced If Yes, spec			jin? (Spi , Puerto	ecify Yes or I Rican, etc.)	No-		k, White	ican Indian, o, etc. hite
9	72 hou	ted	15. Dece (Specify only hig	lent's E	ducation		16a. Dece	dent's Usua	I Occupa	ition	of work	ina	16	b. Kind of Bu	usiness/l	ndustry
21	y within 7 jiene. r than "n ir e Mad	Completed	Elementary/Secondary (0-1		College (1-4o	r 5+)		kind of wor DO NOT us			or work	9				C-l1
7			17. Father's Name (First, Midd	10 1 251	1		Ge	neral	. La		r's Name	e (First, Midd				y School
Maryland 21215-0036	d 2 should be filed th and Mental Hyg ?7 Is marked othe treumetic event,	To Be	Ben Somery									Cook	370, 7412	don oaman	10)	
ary	2 should be and Mental Is marked eumetic ev		19a. Informant's Name/Relati									al Route Nun				
	1 and 2 Health a tem 27 Is		Darlene Bened	dict	-Samaras/ Da	uahter	291.	3 Win	ters	Chas						21401
Baltimore,	Se Jo		20a. Method of Disposition 1 Burial 2 □ Cremati 1 □ Donation 5 □ Othe		∢Removal from Stat		Free	edom C	emet	ery 2	Marcl		Ne	c. Location - ew Fre	eedor	n, PA
Balt	permit. Page Department of Importent: If eny injury or		21. Signature of Funeral Serv	ce Lice	Mu		2:	2. Name an	d Addres	s of Facility	У J.	J. Ha New F	rte ree	nstei dom,	n Mo: PA	rtuary, Inc. 17349
			23a. Part1. Enter the disease shock, or heart failure.	, or con ist only	plications that caus one cause on each	ed the death. line.	Do not en	ter the mod	e of dying	g, such as	cardiac (or respiratory	/ arrest	,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		a_5en	Sis										Onset and Death
	/Medical Examiner		resulting in death)	1	Due to (or a	is a conseque	nce of):									
		ŭ	Sequentially list conditions, if any leading to immediate		b. New Due to (or a	s a conseque		à							-	
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	· Class	us a Hh	0 00	ا م							- 1	
oʻ	exectan and and rial-tra	Exa	resulting in death) Last		Due to (or a	is a conseque	nce of):	1-1								
8760,	cate be executed physician and the burial-transit	dicai		l	_ d											
9	e as t	0	IF FEMALE:			,										
O. Box	requires that the death certific ween signed by the attending p hould be detached for use as:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			2 Fetal di at time of dea	eath 3[⊒Ectopic pr ⊒ Other (sp					_	23d. Dai		very Day Year
S, D	es that gned b be deta	by Pr	Part II. Dther significant con-	litions	contributing to death	but not resulti	ing in the u	inderlying c	ause give	en in Part I.		23e. Di	d tobac	cco use cont	ribute to	the cause of death?
rdis	w require been sig should b		Vulvar	Ca	ncer							1[Yes	2 🗷 No	3 □ Pro	bably 4 Unknown
Vital Record	e law has b	Completed									-	24a. W au pe 1 Yes	itopsy informe	d2 !	prior to death?	topsy findings available completion of cause of 2 No
ita/	iicien: Th certificate rector, pag	Be	25. Was case referred to med examiner?	ical							of Deat	h (Check on	ly one)			
of \	Physicien: this certific ral director,	2	1 Yes 2 No		Hospital: 1 Inpa		R/Outpatie			4 🗀 140	-	me 5 Re				eify)
	fter	ion	27. Manner of Death 1 Natural 5 □ Pe		28a. Date of Ir (Month, I	ojury 2 Day Year) 2	8b. Time o	of 2	8c. Injury Work	rat ⊲? Yes 2.∐l		28d. Describ	oe now	injury occur	rea	
Division	Attending or death. ector: After by the fune	licat	3 ☐ Suicide 6 ☐ Co		De Diese of	niury - At hom	e. farm. st			163 201	-	28f. Location	n (Stree	et and Numb	er or Ru	ral Route Number,
<u>≥</u>	F 6 F	Certification;	4 Homicide del	ermined	building,	etc. (Specify)	.,,		,			City or	Town, S	State)		
	To the Hospitel of within 24 hours af To the Funerel Completely filled in	edical C	29a. Certifier 12 Certifier (Check only one)	fying P cal Exa	hysician: To the bearing and manner	of examinatio	edge, deat n and/or in	th occurred evestigation	at the tim , in my op	ne, date an pinion, dea	d place, th occur	and due to the time	he cau: 1e, date	se(s) and ma and place,	inner as and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and fittle of cer	tifier	()			290	. License	number	-6-		29d	,		n, Day, Year)
			flue	.((les n	0				D58	51	0		03/2	22/	07
			30. Na and address of per	son who	completed cause o	f death (Item 2	23a) (Type	Print)	`							
	Sta	ate.	31. Date filed (Month, Day, Y	ar).	32. Be gi:	strar's Signatu	re	1010								
	Regist		MARS	8		me A	1	ne Bi				-				

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	Marylan	-	artment of rtificate of		and M		giene 20	07	09750	
8	Physici	an	1. Decedent's Name (First, Midd							2. Date of Dea Month		Year	3. Time of Death	
	/Medic	al	JOHN PAUL 4a. Facility Name (If not institution	BROOKS	ne)		4b. City, Town,	or Location o	of Death	MARCH	10 20	007	11:58P M	
1	Examin	ier	6001 Muncaster	-		House		cville	or Doddin		Montgomery			
	Funeral Director		5. Social Security Number 419-07-0636	6. Sex 1 X M 2 ☐ F	Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day	, Year)	Coul		
Ш	0		Usual Residence of Decedent							March 1	3 1919	Ge	orgia	
	arylan show d at	_	10a. State 10b. County		10c. Cit	ty, Town or Lo		_			· · · · · ·		10d. Inside City Limits	
	the Mark	Director	Md. Mor	ntgomery		SIIVe	r Spring						1 ☐ Yes 2 M No	
	h with 23a or st be n	al Dir	15550 Prince	Frederick W	J ay		10f. Zip Code	209	906		Og. Citizen of V United		*	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Hylgiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	s? ⊒ No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No		gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14. Race Blac Specify	k, White,	ean Indian, etc. ite	
5-0	"natu	letec	15. Deceder (Specify only highe	nt's Education est grade completed)		i (Give	dent's Usual Occi kind of work don DO NOT use retir	e durina most	t of workii	ng	16b. Kind of Bu	siness/In	dustry	
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ylaı	2 should be and Menta is marked aumatic ev	To E	Paul Porter	Brooks				Mar		Counglor ————			700 1	
	ges 1 and 2 should tt of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relations Irene M. Broo			1	ng Address (Stree Prince				-		Md. 20906	
	ges 1 and 2 t of Health If item 27 i		20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation	2 Demoval from Sto		Place of Dispo cemetery, crei	sition (Name of natory or other pi	ace)	D	Date	20c. Location -	City or To	own, State	
tim	Pages tment of l tant: If its jury or o		4 □ Donation 5 □ Other (8	Specify)		_	itan Cre			12/07	Alexar	ndria	, Va.	
Bal	permit. Page Department of Important: If any Injury or once.	0 0	21. Signature of Funeral Service	N-Ba	rke	/ M	Name and Add Uriel H.	Barbe	ér Fι		Home ille, Md	l. 2	0882	
		g (1	23a. Part1. Enter the disease, o shock, or heart fallure. Lis	r complications that caus t only one cause on each	ed the deatl line.	h. Do not ent	er the mode of dy	ing, such as	cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ND STA		HEIMER'S	DEME	AITV					
	Examiner		Occupation for the last	bue to (or a	as a conseq	dence or,								
	sit sd	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to or a	as a conse	uence of:							-	
_6	execute n and al-trans	Examine	that initiated events resulting in death) Last	c Due to (or a	as a conseq	uence of):								
8760,	icate be executed physician and s the burial-transit	dical E		d										
	ertifical	Medi	IF FEMALE:											
.O. Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	ıldeath 3□	Ectopic pregnan Other (specify)	су			23d. Date Mor		ery Day Year	
S, D	w requires that the diperent signed by the should be detached	by Pt	Part II. Other significant conditi	ions contributing to death	but not resi	ulting in the ur	nderlying cause g	iven in Part I.		23e. Did to	bacco use contr	ibute to ti	ne cause of death?	
ord	requir een si	ted								1 🗆 Y	es 2 □ No	3 Prob	pably 4⊠Unknown	
Division or Vital Records,	ne law has b ge 2 sł	Completed								24a. Was a autops	sv p	Vere auto rior to co eath?	psy findings available mpletion of cause of	
tal	sician: The certificate harector, page		25. Was case referred to medica	al				26 Place	of Dooth	1□ Yes	2 🔀 No 1		2□No	
<u> </u>	nysicia nis cer direct	To Be	examiner? 1	Hospital: 1 ☐ Inpa	itient 2 🗍	ER/Outpatien	t 3□ DOA O	hor:			ence 6 🖾 Othe	er (Specif	HOSPICE	
o uo	ling Pl	:uo	27. Manner of Death 1 Natural 5 □ Pendir	ig .	njury Day Year)	28b. Time of Injury	W	ury at ork?	2		ow injury occurre			
isio	Attend death ctor; ,	icati	3 ☐ Suicide 6 ☐ Could		niury - At ho	ome. farm. str	M 1[eet, factory, office]Yes 2∏N		28f Location (St	treet and Number	e or Burn	d Route Number,	
<u>≥</u>	alor /	Certification:	4 ☐ Homicide determ	building,	etc. (Specifi	y)	,			City or Town	n, State)	or or riare	ir riodle ivarriber,	
	To the Hospital or Attending Physician: TI within 24 hours after death. To the Funeral Director. After this certificate completely filled in by the funeral director, pa	Medical (29a. Certifier 11 Certifyin (Check only one)	ng Physician: To the best Examiner: On the basis and manner	of examina	wledge, death	occurred at the vestigation, in my	time, date and opinion, dea	d place, a th occurre	and due to the c ed at the time, d	ause(s) and mai late and place, a	nner as s and due to	tated. o the cause(s)	
	Vithil To th	Me	29b. Signature and title of certifie					se number		2	9d. Date signed			
1	140			m Dill				0580:	32		Marc	112	2007	
·	•		30. Name and address of person		death (Item	1 23a) (Type,	Print)							
			CYNTHIA M. W	ILLIAMS, D.	0.	6001 N	MUNCASTE	R MILL	ROA	D, ROCK	VILLE, I	MD.	20855	

State of Maryland / Department of Health and Mental Hygiene 2007 09751 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Madical Examiner Elias Albert Bitar 1507 hrs March 11, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or **Funeral** 219-29-9259 Months Days Hours Director Country)Lebanon 1 xM 2 F Yrs 53 March 15. 195 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. Yes 2 XNo Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene Maryland Montgomery Gaithersburg Director 10e. Street and Number 10f. Zip Code 10a Citizen of What Country 17718 Silkcotton Way 20877 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14 Race - American Indian, Black or items? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 Never Married 2 Married 2 x No Yes Divorced If Yes, Give Year 1 Yes 2 X No specify Specify: White Widowed marked other than "natural", c event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 Owner/Operator 4 Warehouse/Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Elias Bitar Abla Iskander Tayem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 17718 Silkcotton Way, Gaithersburg, MD 20877 Doris Bowen/ Wife 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a Method of Disposition March crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2007 Silver Spring, Maryland mportant; Donation 5 Other Specify: 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. Signature of Funeral Service Licensee 500 University Blvd. W Spring MD 2
Appr ximate Interval Aart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and trans Physician/Medical UNPENDED AMENDED Box 68760, tending phys use as the b IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by the betached Part II. Other significant conditions o þ 1 Yes 2 No 3 Probably 4 V Unknown σ. Completed Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) or Attending Physician: Division of Vital Be Hospital: 1 Other₄ Nursing Home 5 Residence 6 2 ER/Outpatient 3 DOA Other Inpatient this 1 🗸 Yes After t 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 V Natural Pending Yes 2 No death. Director: the 2 Investigation Accident npletely filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide (Specify) Fo the Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 12, 2007 30. Name and address of person who compléted cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Day, Year) 2007 Registrar's Signature State

DHMH 17 Rev 1/2001 **DCME 2006**

Registrar

			1 - For State Registrar	State of Marylan		artment of F			giene Reg. No.	007	03752	2
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ıth		3. Time of Death	
	Physici /Medio		CATHERINE ESSIE	CARROLL				MARCH 1	$12^{\text{Day}}_{\bullet}$	2007 Year	1:10A	М
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	ath	4c. 0	County of Death	111011	
			Southern Many	land Hosp	tal	CI	Inton		Pr	ince 6	evel-	
	Funeral		5. Social Security Number 6. Se	7. Age (in yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		7	9. Birth	place (State or Foreign	gn
	Director		214-32-2087	M 2E3F 60	Yrs.	World Days	1 IOUIS IVIII	04-11-1	1946	WASHI	NGTON, DO	,
	Pue M		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation					10d. Inside City Limit	
	daryli eho	ō									1 Yes 2 N	
	28a-	ect	MD PRINCE GE 10e. Street and Number	ORGE FORE	STVILL	L 10f. Zip Code			10- 011-			_
	with	Funeral Director	3725 DONNELL DR #	103		20743			_	en of What Cou J.S.A.	ntry?	
	leeth	era	11. Marital Status	12. Was Decedent Ever in U	S 13 V		ispanic Origin? /	Specify Yes or No-		4. Race - Ameri	can Indian	
10	r Iten	ᇤ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	1	Yes, specify Cuba	an, Mexican, Pue	erto Rican, etc.)	'	Black, White,		
98	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	,	☐ Yes 2 No	Specify:		5	Specify: BI	ACK	
0	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other then "netural; or items 23e or 28e-f ehow event, the Madicel Examiner must be notilied at	Completed	15. Decedent's Edu	cation		ent's Usual Decup			16b. Kin	d of Business/In	dustry	
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7	er th	Son	9th			HOMEMAKEI	3		F	PRIVATE		
p	al Hy	Be (17. Father's Name (First, Middle, Last)					ame (First, Middle,	Maiden S	Битате)		
yla	Meni Meni arke	ို	JAMES P. CARROLL		.,		ESSIE M.	PINKNEY				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Items 23a or 28a-1 ehow any injury or other traumatic event, the Modical Examiner must be notified at once.	0.3	19a. Informant's Name/Relationship (Ty LARRY CARROLL/SON	pe, Print)	19b. Mailin	g Address (Street a	and Number or F	Rural Route Number NHAM HILI	r. City or	Town, State, Zin	Code)	
	and ealth m 27								ר כטב	20704		
Baltimore,	t of H If Ite or oti		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □ P	emoval from State	emetery, cren	sition (Name of natory or other place				ation - City or To		
Ē	tmen tant:		4 □Donation 5 □ Other (Specify)	HAR	MONY C	EMETERY	03-1	6-2007	LANI	OOVER, M	ID	
3a	Deparitimpor impor in porce.		21. Signature of Funeral Service License	1 00	22	. Name and Addres	ss of Facility J	B JENKINS	FUN	NERAL HO	ME	
_	0.07 = 0		1 - D. M -	-hall				ANDOVER,		20785		
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	طعه					nt Di	Approximate Interval Between Onset and Death	
ı	Examiner			Due to (or as a consequ	uence or):							
		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):							_
	cuted 3d ransit	Examiner	Cause (Disease or injury that initiated events									
Ó	icate be executed physicien and s the burial-transit	Ä	resulting in death) Last	Due to (or as a consequ	uence of):				-			
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9	ing ph		IF FEMALE:									-
Вох	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	iclan/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnancy			23	d. Date of delive	•	
o.	the a	sic	1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown	eath 5	Other (specify)				Month	Day Year	
<u>Ч</u>	d by letach	Physi		A. P. A. J.	tet - t - u							
ŝ	res tha	٦	Part II. Other significant conditions con	induting to death but not rest	ulting in the un	derlying cause give	en in Part I.				ne cause of death?	
Records,	w require been signature	Completed						1 _ Y €	9\$ 2 □	No 3 ☐ Prob	ably 4 Unknown	1
ec	has b	힡						24a. Was a autops		24b. Were auto	psy findings available	8
_		ပွဲ						perform 1 □ Yes 2	ned?	death?	2 No	
Vital	sician: The certificete ha	Be	25. Was case referred to medical examiner?					eath Check only on	θ)			
	Physic this call dir	2	#E1103 2 140		ER/Outpatient		4 🗆 Nursing .	Home 5 ☐ Reside			1)	
Ĕ	ding F	ë	27. Manner of Death 1. ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury	occurred		
Division of	Attending Physician: r death. ector: After this certific by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No					
\leq	2 # F =	ξl	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and i n, State)	Number or Rura	l Route Number,	
	Hospital 4 hours a Funeral t tely filled		29a Certifier	Inion To 4	. (-)							
	HOY TEL	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examir one)	ician: To the best of my knowner: On the basis of examinat	wiedge, death ion and/or inv	occurred at the time estigation, in my op	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	ause(s) ar ate and p	nd manner as st lace, and due to	ated. the cause(s)	
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier	and manner stated.		29c, License	number	20	9d. Date	signed (Month,	Dav. Year)	
•	ખ ≱ ⊷ ૪		1001	10 to		./	-			-		
	(2)	-	30. Name and address of person who do	moleted source of death in	5	150	0557	2/ /	Ma	el 14	2001	_
^	# 1 1 1		SS. HARRIS WING AUGIOSS OF POISON WIND EQ	mpiotou vauso ut death (Item	EJAN LIVOR P	OUTO					and a	
R	(4)		511.2/2	2/12 Ton 2.	301 11	rostal	Dar	· Cha-	- 0	Ma	6	
2	Sta	ie.	31. Date filed (Month, Day, Year) MAR 1 5 2007	32. Registrar's Signat	01 H	spital	Drin	e char	-g	Ma	y/and	

Latez Cooper State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day March 4, 2007 Medical Examiner 1305 hrs Latez Cooper 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's County Hospital Prince George's Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or **Funeral** Foreign Washington Country DC Months Days Min. Hours Director 215-02-8144 28, 38 December 1 X M 2 F Usual Residence of Decedent 10d Inside City Limits 10a. State 10c. City, Town or Location s 23a or 28a-f show a notified at once. X Yes 2 No Prince Georges Fort Washington Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20744 USA 5231 Haras Pl. #AC Funera 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13 Was Decedent of Hispanic Origin? (Specify Yes or Noor items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes **Black** Specify: 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th Tow Truck Driver Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bill Cooper Ruby Α. Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7900 Allentown Rd., Ft. Washington, MD Ruby A. Cooper/ Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place t: If i 1 X Burial 2 Cremation 3 Removal from State Lincoln Memorial Cem. 3/12/2007 Suitland, Maryland Donation 5 Other Specify 21. Signature of Funeral Service Lice 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD Approximate Interval ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Madical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate natise Enter Underlying Carise (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical tending physician a use as the burial -UNPENDED AMENDED Box 68760. 23d Date of deliver 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown has been signed by the 2 should be detached for P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has death? performed' page ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Other: Nursing Home 5 Residence 6 Other: DOA After this No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred Mar 4, 2007 Certification Subject shot self 1210 hrs Natural 1 Yes 2 ✔ No Pending the Funeral Director: hours after death Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 11213 Hannah Way, Mithcellville, MD determined (Specify) steps 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 5, 2007 O.C.M.E. en 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day Year MAR 1 5 2007

32. Registrar's Signatur

State of Maryland /	Department of	of Health	and Menta	l Hvaier
Clato of marylaria,	Dopartinone	or i roaitii	and mone	a ray gior

			1 - State C State Registrar	Maryland / Dep <i>Ce</i>	artment of F ertificate of a		vientai Hygie Reg		·
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Erika Conine				2. Date of Death Month February	Day Year 24, 2007	3. Time of Death 4:10 a _M
	Exami		4a. Facility Name (If not institution, give street and nu 1511 Ray Road, #T3	mber)		r Location of Death		4c. County of Death Prince Geo	orge's
	Funeral Director		5. Social Security Number 214-42-6363 6. Sex 1 ☐ M 2 🕰 F	7. Age (In yrs. last birthday 65 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthp Coun 41 Germ	ilace (State or Foreign htry) any
	laryland show ed at	'n	Usual Residence of Decedent 10a. State 10b. County Maturificand Philippe County	10c. City, Town or L				1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the N 28a-f notifie	Director	Maryland Prince George 1 10e. Street and Number	3	Hyattsvi	lle	100	. Citizen of What Coun	
	with 3a or 1 be r		1511 Ray Road, #T3			782	109	u.s.A.	•
10	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Dec Armed Formula 1	2 2 No	Was Decedent of H If Yes, specify Cuba		pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	an Indian,
9009	hours af tural", or al Exam	þ	3 ☐ Widowed 4 ☐ Divorced If Year or D	ive Dates:	1 ☐ Yes 2 🔏 No edent's Usual Occup	Specify:	16		Vhite
215	ithin 72 ne. lan "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give	e kind of work done o DO NOT use retired	durina most of wor	king	b. Kind of Business/Ind	
7	led w lygier her th	ပ္ပြဲ	12		Manager	40.14 1.14	(57)	Property F	Rental
and	ibe fill	Be	17. Father's Name (<i>First, Middle, Last)</i> John Bower				ne (First, Middle, Ma	,	
Ĕ	shoutd od Me mark matic	은	19a. Informant's Name/Relationship (Type, Print)	19h Mail	ing Address (Street		y Bowers S	ity or Town, State, Zip	Code
≅	nd 2 salth ar 27 is r trau		Edward Conine - Spouse					., Maryland	
Baltimore, Maryland 21215-0036	ages 1 a ent of Hea t: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from	State 20b. Place of Disp	osition (Name of ematory or other place OLN	ce)	Date 20	c. Location - City or To	wn, State
Saltin	ermit. P lepartme nportan ny Injur nce.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Cremato	<u>ry</u> 2. Name and Addre: 1.ne.s-R1.na	ss of Eacility Ldi Fune	12007 Beral Home.	<u>ientwood, N</u> Inc. Iver Sprin	laryland
68760,	Medical Examiner B physician and as the purial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of): (or as a consequence of): (or as a consequence of):					
P.O. Box 687	ath cert	Physician/Medical	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy	,		23d. Date of delive Month	ery Day Year
ds, F	uires that the de r signed by the a ld be detached i	by	Part II. Other significant conditions contributing to d	eath but not resulting in the u	underlying cause give	en in Part I.		co use contribute to th	ne cause of death?
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Vita		Be C	25. Was case referred to medical			26. Place of Dea	1 Yes 2 th (Check only one)	No 1∐Yes	2 No
	hysic his ce I direc	To E	examiner? 1 ☐ Yes 2 【其No Hospital: 1 ☐	Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Othe			e 6 □Other (Specif)	·)
Division or	Jing P 1. After t funera		2 Accident investigation	of Injury oth, Day Year) 28b. Time of Injury	Worl	y at k? Yes 2 □ No	28d. Describe how	injury occurred	
DIVIS	P Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	e of injury - At home, farm, st ing, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifler (Check only one) 1 Certifying Physician: To the band mar	e best of my knowledge, dea pasis of examination and/or in oner stated.	th occurred at the tin	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier		29c. License	e number	29d.	Date signed (Month,	Day, Year)
)	Oi		Mich Frynns		D233	308	М	arch 1, 20	07
	1 -		30. Name and address of person who completed cause Victor M. Priego, M.D.,	se of death (Item 23a) (Type,		uite 4100	. Bethesd	a. Marulan	d 20817
Ī	Sta Registi			egistrar's Signature	4		,	, lovery court	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar Registrar Registrar Registrar Registrar 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 12:13 AM Jane H. Craver 10 2007 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F Yrs. Director 578-01-8301 90 June 30, 1916 Maryland Usual Residence of Decedent death with the Maryland 10b. County Washington 10c. City, Town or Location 10d. Inside City Limits 10a, State show be notified at 1 ☐ Yes 2X No Director Williamsport Frederick Maryland Myersville 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. 13421 John Martin Drive 23a or 21773 21795 86 Ashley Court must. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, or Items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2**k** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank of America Customer Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Magruder ဥ Maynard Hoyle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13421 John Martin Drive, Williamsport, Maryland 21795 Terri McAtee - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other places of John's Episcopal 20c. Location - City or Town, State 20a. Method of Disposition 1 🗷 Burial 2 Cremation 3 Permoval from State 4 □ Donation 5 Other (Specify) Cemetery 3/13/2007 Olney, Maryland 21. Signature of Juneral Service 22. Name and Address of Facility licer Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part . Enter the diseas shock, or heart failure Approximate Interval Between Onset and Death se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and Due to (or as a consequence of) physician sthe burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2, ☐ No Year Month Day 5 ☐ Other (specify) 9□Unknown 9 Unknown ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş **4** Únknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3□ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

29b. Signature and title of certifier

30 Name end address of

ABOUL

WAHEED MD -12821- OAKHIL AVE. HAGERSTOWN MD 21792 31. Date filed (Month, Day, Year) MAR 14 2007

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end item 1 per doc 2866 4-6-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) William Floyd Campbell Sr. Day Month Year **Physician** 02 /Medical Prince County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EGIOVAL .aure If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) Months 1 XM 2 □ F 74 Yrs. 237-44-5756A 28,1932 Director Apr Ν. Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified XXes 2 □ No Director Prince George Laurel Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 7208 Carriage Hill Drive 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 Yes 25100 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: by 3 Widowed 4 ivorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Roofer Univ Of Maryland 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robinson ည Della Link Campbell 19a. Informant's Name/Relationship (Type (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau Emma Lee Campbell 230 Red Jade Dr, Upper Marlboro, Md 20774 20b. Place of Disposition (Name of cemetery, crematory or other place). Date 20c. Location - City or Town, State 20a. Method of Disposition MXBurial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial 3/16/07 Landover, Md 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Signature of Funeral Service Licenses 23a. Part1. Enter the 18 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on unch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** zonar /Medical Due to (as a consequence of **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a) insequence of Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2200 certificate l 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2X ER/Outpatient 3 □ DOA Director: After this in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of De th 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending Iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) nner stated the within ? 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2 0 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elwood S. Holland, M.D. SIE 6005 RD 0 Vè

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (M

egistrar's Signature

		1 - For State Registrar	State of Maryland / D	,	rtment of H tificate of L		, ,	iene g. No.	07	0975
D		1. Decedent's Name (First, Middle, Last)	-			2. Date of Deat		Year	3. Time ol Death
Physic /Medi		Chuen Siu Cheng					March			1:03 A M
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat		4c. County	of Death	
		Saint Mary's Hosp			Leonard			St.	Mary	's County
Funeral		5. Social Security Number 6. Se	M 2□F	thday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Day,		Cou	
Director		577-72-0881 Usual Residence of Decedent	59	113.			June 16	1947	Ch	ina
/land		10a. State 10b. County	10c. City, Town	n or Loc	alion					10d. Inside City Limits
Man	to	MD St. Mary	's Co. Levir	orto	n Park					1 ☐ Yes 2 XNo
h the	irec	10e. Street and Number	D CO. DOMI	1800	10f. Zip Code		1	Og. Citizen of \	Whal Cou	ntry?
11 wi	ie D	46713 Midway Dri	ve		20653			U.S.A.		
r dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-		e - Ameri ck, White,	can Indian,
s efte	by Fu	1 Never Married 2 Married	1 ☐Yes 2 XNo If Yes, Give		☐Yes 2XNo	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify		inese
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Mental Mental rked o	To B	Kui Cheng				Yin C	hang			
2 should and Men Is marke	-	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b.	Mailing	Address (Street a		ral Route Number,	City or Town,	State, Zip	Code)
		Adam K. Cheng (So	n.)37	710	Elberta l	Lane. Hu	ntingtow	Morey	land	20630
rmit. Pages 1 ar partment of Hea portant: If Item y Injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of	Dispos y, cremi	ition (Name of atory or other place		ntingtown Date	c. Location -	City or To	own, State
permit. Pages Department of Important: If It eny Injury or o		4 Donation 5 Dother (Specify)	Lincol	n M	lem. Ceme	tery	h 20, 2007	Suitla	nd, I	Maryland
permit. Departimport Import eny Inj		21. Signature of Funeral Service Licens	-	22.	Name and Addres	s of Facility Le	e Funeral	Home	Calv	ert, P.A.
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law requires thet the as been signed by the 2 should be detached	'P	Part II. Other significant conditions cor	stributing to death but not resulting in	the unc	derlying cause give	n in Part I.	23e. Did lob	acco use conli	ribute lo th	ne cause of death?
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w requir been s	lete						24a. Was an	245.1	Mass 2012	- finding and all the
e - 6	Completed						autopsy		prior to condeath?	psy findings available npletion of cause of
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Phys or this oral di		27. Manner of Death	t ☐ Impatient 2 ☐ ER/Out 28a. Dale of Injury (Month, Day Year) 28b. Ti		3□ DOA 28c. Injury Work	4 Nursing H	ome 5 Resider			()
Attending In death.	tio	1 Matural 5 Pending 2 Accident investigation	(Month, Day Year) In	ijury		? ′es 2 ∐ No		. ,		
₹ ≥ 6 6	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fare building, etc. (Specify)	m, stree	et, factory, office		28f. Location (Str. City or Town,	eet and Numb State)	er or Rura	l Route Number,
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To the within 2 To the complet	ž	29b. Signature and title of certifier	1.		29c. License		29	d. Date signed	(Month,	Day, Year)
			Mes		060	888		03	/12	107
,		30. Name and address of person who co	mpleted cause of death (Item 23a) (1	Туре, Р	rint)		1	1	-	,
6		Rakhi Krishnan. M	1.D. 26840 Point	In	okout Rd.	- Leona	rdtown M	D 2065)	
Sta	ite ar	31. Date filed (Month, Day, Year)	32. Registra Signature	<u>Le</u>	A.R.					

		_	For State Registrar	State of Ma		epartment Certificate			ind Me		iene og. No.	007	09758
	· ·		1. Decedent's Name (First, Middle, Last)					2	Date of Deat	th Day	Year	3. Time of Death
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a l	/Medic Examin		4a. Facility Name (If not institution, give					Location of	f Death			ounty of Death	
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	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birtho	lay) If Under	1 Year	If Under 2		Date of Birth (Month, Day,			lace (State or Foreign
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	ō		Usual Residence of Decedent										
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	B Ma	cto	MD PRINCE G	EORGE'S	LAI	IDOVER							1 ☐ Yes 2 🙀 No
	th th or 28	lire	10e. Street and Number			10f. Zip	Code			1	0g. Citize	n of What Cou	ntry?
	15 w 23a	Funeral Director	6927 FORREST TERR	ACE			20	785				USA	
	r dea	ine!	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Deced	dent of His	spanic Orig n, Mexican	gin? (Spec , Puerto R	ify Yes or No- can, etc.)	14	. Race - Americ Black, White,	
9	or it		1 Never Married 2 Married	1 ∐ Yes 2/∐ N If Yes, Give Year or Dates:	0	1 ☐ Yes	X No	Specify:			S	pecify: BLA	CK
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Maryland	~ ~ ~ ~				- 1								
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Baltimore,	t. Pa rtmer rtant		4 Donation 5 Other (Specify)		METROI	POLITAN						ANDRIA,	MD, INC.
Bal	permit. Pages 1 Department of the Important: If ite any injury or ot once.		21. Signature of Fulleral Service Licens	01 - 11	1	22. Name an						AND, MD	
			23a. Parl. Enter the disease, or comp	Mall	the death. De no	ontor the med						MD, MD	Approximate
			stock, or heart failure. List only o	ne cause on each lin	e.	onter the mod	or dying	y, such as	cardiac or	respiratory arr	031,		Interval Between Onset and Death
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*	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of	: '							St.
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Z:	Physicien: The this certificate ir al director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only or			
ð	shy this ald	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injur			77	4 🗆 140		e 5 ☐ Resid 3d. Describe h		Other (Speci	fy)
L	1 E	ē	1 Natural 5 ☐ Pending	(Month, Day	Year) Inj	iry M	28c. Injury Work	(? Yes 2∐t			o		
isi	deatl deatl ctor: / the	Ca	3 ☐ Suicide 6 ☐ Could not be	28e Place of Inju	ıry - At home, farn					3f, Location (S	treet and	Number or Rur	al Route Number,
Division	5 # 5 =	Certification;	4 ☐ Homicide determined	building, etc	. (Specify)	, 01.001, 140101)	y, omo			City or Tow			
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 11X Certifying Phy	sician: To the best of	of my knowledge.	death occurred	at the tim	e date an	d place, ar	nd due to the c	ause(s) a	nd manner as :	stated.
	Hos 24 h Fur etely	edicai	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	examination and/	or investigation	i, in my op	oinion, deal	th occurre	d at the time, o	ate and p	lace, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier			290	c. License	number			29d. Date	signed (Month,	Day, Year)
	FSFO		MON	Suger_			b _	-178	74		3	-9-07	7
0	111	1	30. Name and address of person who o	om ted cause of de	eath (Item 23a) (T	vpe. Print)						. /	
_	(4)		S. M. NAYAR		717- 38	2" AVE	Co.	TTAG	FCI	TY)	MD	207	22_
3	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signature								
	Regist		MAR 1 4 2007	Total D.	ar's Signature								
-													

07-01973 Patrick D. Cope Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

atrick D. Cope		State of Maryland / De	partment of Certificate of		Mental H		eg. No. 2	007	0975
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)				Date of Dea Month	th	Year	3. Time of Death
ledical Examir		Patrick Dean Cope		41. O'i. T		March 13,	2007	nty of Death	0958 hrs
		4a. Facility Name (if not institution, give street and number) Peninsula Regional Hospital		4b. City, Town, or L Salisbury	ocation of Deatr		Wicor	nico	
Funeral			s. last birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_		Foreign	place (State or
Director		219-82-8599 1XM 2 F 42	Yrs.		1 Todis IVIII	09/10)/1964	Mai	ryland
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Locati	on					10d. Inside City Limits
ž .		Maryland Wicomico	Salisbur						1 Yes 2 X No
daryland 28a-f show 1 at once.	Director	10e. Street and Number	Dairobar	10f. Zip Code		1	0g. Citizen of	What Counti	ry?
th the Mary 23a or 28a notified at	Dire	27984 Craven Court		21801			USA		
n with	eral	11. Marital Status 12. Was Decedent Ever in		s Decedent of Hisp es, specify Cuban,				ace - America /hite, etc.	an Indian, Black,
r death or ite must	Funeral	1 Yes 2 X No	- 1			, , , , , , , , , , , , , , , , , , , ,		·	ite
rs afte ural", miner	2	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 16a Deceder	Yes 2 X No		work done	Speci 16b. Kind of	f Business/Inc	
2 hou "nate	et e	Elementary/Secondary (0-12) College (1-4 or 5+)	during m	ost of working life.	DO NOT use ret	ired)			
5-0036 iled within 7 Hygiene. I other than	ompleted	12	Calend	lar Opera				rtech	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	O	17. Father's Name (First, Middle, Last)		1		e (First, Middle, ia Ann I			
2121 2121 suld be fi Mental] marked	Be	Ralph Dean Cope 19a. Informant's Name/Relationship (Type, Print)	19h Mailine	Address (Street					Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	의	Shirley Ann Cope/wife		4 Craven					
Dre, MD 21215-003 ss I and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other the traumatic event, the Med			Ob. Place of Dispos		netery,	Date	20c. Locati	on - City or T	own, State
		1 XBurial 2 Cremation 3 Removal from State 5	Springhii Gardens	I Memory	3/3	L7/07	Hebr	on, MI)
Baltimore, permit Pages I an Department of Het Important: If ite	Ì	21. Signature of Funeral Service Lichnsee			Facility Funeral	Home P	rofess	ional	Associatio
© ₹2 € €	3 16	23a. Part I. Enter the disease, or complications that caused the de		SOI Show	HITT KC	ı., Salı	spury,		804 Approximate Interval
Physician Maria I		failure. List only one cause on each line.							Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrythm Due to (or as a consequence)					ascular	015-AS	
and the second		Sequentially list conditions, b.							
	miner	if any, leading to immediate cause. Enter Underlying Cause	ce of):						
	Exam	(Disease or injury that initiated events resulting in death) Last	ce of):						(A)
be executed sician and urial - transit	a E	d							
	edical	X UNPENDED #250,27,28a-f,		67 , 5/8/07	TŢ		and Det	o of delivery	
876 tificate ng phy as the	n/M	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth		etal death 3	Ectopic pregr	nancy	Mont	te of delivery th Da	ay Year
Box 6876: death certificate the attending phy	sicia	past 12 months? 1 Yes 2 No 9 Unknown	of death 5 O	ther (Specify)					
m & a & a	Physician/M	Part II. Other significant conditions contributing to death but n	not resulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?
ires that the signed by I be detache	by	Takin Galay organican contains to the contains and the co		, , ,		1 Ye	es 2 No	3 Proba	ably 4 🗸 Unknown
ords, w require s been si should b	eted					24a. Was		4b. Were aut	opsy findings available ompletion of cause of
cords e law requ e has been ge 2 should	Completed						ormed?	death?	
tal Rectian: The l		25. Was case referred to medical		26.Place	of Death (Check				
Vital I hysician: this certifi il director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA	Other Nurs	ing Home 5	Residence		
J of Jing Ph	n: T	27. Manner of Death 1 Natural 5 Panding 28a. Date of Injury (Month, Day, Year)	28b. Time of		y at Work?	28d. Describe	how injury oc	curred	
Sion trend death ctor: y the f	atic	lovestigation Fnd 3/13/200		U alli I	es 2 X No	unk.	(Street and N	umber or Rur	ral Route Number, City
Division of Vital Records, bospital or Attending Physician: The law requir hours after death meral Director: After this certificate has been siy filled in by the funeral director, page 2 should by	Certification:	3 Suicide 6 X Could not be determined (Specify) Dental		et, ractory, office b	unding, etc.	or Town,	State)Bay (Shore Se	rvices MD
Division Hospital or Attence the hours after death Funeral Director: tely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my know	wledge, death occu	irred at the time, da	ate and place, ar	nd due to the cau	use(s) and ma	nner as state	ed.
To the Hos within 24 h To the Fur	Medical	one) 2 ✓ Medical Examiner: On the basis of examination and manner stated	on and/or investiga	ation, in my opinion	, death occurred	at the time, date	e and place, a	nd due to the	cause(s)
To wit	Me	29b. Signature and title of certifier		29c. Licens		-			nth, Day, Year)
		Ulio 2		O.C.I	M.E.		March 1	14, 2007 - 	
		30. Name and address of person who completed cause of death Ana Rubio MD. Assistant Medical Examiner		Street, Baltimo	ore MD 2120	— — D1			
	tate	100 000 1100			, 1110 2120				
Regis		MINES SET 2007 #/a	15 An	ede					
		1100-03100	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 430 M MARCH 2007 Dorothy M. Carter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISKIKY PINIASUUM REGIONAL CENTER NICOMIC Medical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 28, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2 T F Maryland Director 193-20-3242 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Eden MD Wicomico Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21822 USA 4189 S. Upper Ferry Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. I ☐ Yes 2 No f Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3√ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Self-employed Private Duty Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Tull David Jones ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Pitts/Son 4189 S. Upper Ferry Road - Eden, Maryland 21822 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Friendship UMC Cemetery March 17, 2007 Allen, Maryland 21810 4 Donation 5 Dother (Specify) 21. Signature of Fineral Service License 22. Name and Address of Facility Salisbury, Maryland 21801 1213 Jersev Road Jolley Memorial Chapel, P.A.tions that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause unleach light Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) **Physician** 9007 heren /Medical Dy to for as a consequence of) Examiner Monays Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical as the t attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a Ö 9☐Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? res 20 No certificate or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 🗌 Yes 1 Inpatient 3□ DOA ٩ this 27. Manner of Death
Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar (Check only one)

29b. Signature and title of certific

1+-Kobins, M.D. illiam 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Maryl		artment of I			giene Reg. No. 🔿 🔿	07 00761
		77	Decedent's Name (First, Middle, L	.ast)				2. Date of Dea	ath CU	3. Time of Death
к	Physici		Ruth C	adwallacker				Month 03	, _	Year 1013 M
No.	/Medic Examir	40.0	4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death		4c. County o	- 1 1010
A.	Lxaiiii	101	Coastal Hospic	e at the La	Ke	Salist	oury		Wico	mico
	Funeral		Social Security Number 6.	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birt	h	Birthplace (State or Foreign Country)
н	Director		218-46-1137	1□ M 2 X F 60	Yrs.	World Days	Hours Will.		/1946	Maryland
	pu ,		Usual Residence of Decedent	100	. City. Town or Lo	neation				10d. Inside City Limits
	aryla show dat	-	10a. State 10b. County			ocation				1 ☐ Yes 2 🗚 No
	8a-f	octo	Maryland Worces	ster	Berlin	1407 771 001			40 - OWI FW	
	with t	Funeral Director	10e. Street and Number			10f. Zip Code	,		10g. Citizen of W	nat Country :
	s 23	eral	632 Ocean Parkwa	12. Was Decedent Ever	in II C 12	2181		pocify Voc or No	USA 14 Bace	- American Indian,
	er de item ner r	, i	11. Marital Status 1 ☐ Never Married 2 【X Married	Armed Forces?	110.3.	If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Black	k, White, etc.
36	rs aff		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed by	15. Decedent's	Education	16a. Dece	dent's Usual Occu	pation	1	16b. Kind of Bus	siness/Industry
15	nin 72 n "na Medic	plet	(Specify only highest of Elementary/Secondary (0-12)	Grade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of world)	rking		
212	d with giene grene rr tha	E S	12	4	Hum	an Servi	ces		_State (Government
	e filed al Hygi other vent, tl	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Nar	ne (First, Middle,	Maiden Surname	э)
<u>lar</u>	ould be Mental arked o	TO E	Henry Zech				Kather	ine L. n	nyers	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ľ	19a. Informant's Name/Relationship			-	t and Number or Ri			State, Zip Code)
	1 and 2 Health em 27 i		Robert Cadwallac				arkway, B	erlin, N	4D 21811	
ore	of He fiter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	DRamoval from State	 Place of Disposers, createry, createry 	osition (Name of matory or other pla	ace)	Date	20c. Location - 0	City or Town, State
E	Pages nent of I ant: If it		4 □ Donation 5 □ Other (Spe	cify)	Salisbur	y Cremato	ory 3/1	3/07	Salisbu	ıry, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Servi	censee	2	2. Name and Addr	ess of Facility	Home Pro	fessiona	1 Association
m	9 9 E 8 9	Y 1	Cut of And	ney (F)P		501 Snow	Hill Rd.	, Salisb	ury, MD	al Association 21804
	_		23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that caused the	death. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
4	Physician	71 T	Immediate Cause (Final disease or condition	Metesta	ti FA	donetri	el C	proc	_	Onset and Death
	/Medical		resulting in death)	a. Due to (or as a cor	nsequence of):					
	Examiner		Coquentially list conditions	b						
	P +	ner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying	Due to (of as a con	is equel to of):					
	cuted nd ransi	Examiner	than, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с						
0	ate be executed nysician and he burial-transit		resulting in death) Last	Due to (or as a cor	nsequence of):					
3760,	ate be nysici	cal		d						
89	ng ph	Physician/Med	IF FEMALE:		305-5-					
Вох	ith ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐		⊒Ectopic pregnand	су		23d. Date Mor	e of delivery nth Day Year
	e dea	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)			IVIOI	ill Day Teal
P.0	at the	Phy	9 ☐ Unknown		4 141 1- Ab		in a la parti	OOo Did 4	ahaasa waa santii	ibute to the cause of death?
	w requires that the death certifical been signed by the attending phy should be detached for use as th	þ	Part II. Other significant conditions	s contributing to death but no	or resulting in the t	indenying cause gi	venin Panti.		~/	
Records,	equil sen s	Completed						10	Yes 2 No	3 Probably 4 Unknown
ec	The law I te has be bage 2 sh	ple						24a. Was auto	psy p	Vere autopsy findings available prior to completion of cause of
R	The ate h page	ρ						perfo 1∐ Yes		leath?
Vital	Physiclan: The law requer this certificate has been ral director, page 2 shoult	Be (25. Was case referred to medical examiner?			1.05-		ath (Check only o	one)	
7	Physic this or al dire	2	1 ☐ Yes 20 No		2 ☐ ER/Outpatie	III JUDOA	her: 4 Nursing I		dence 6 □Othe	
0	ng P	ü	27 Manner Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time (Wo	ork?	28d. Describe	how injury occurre	ed
Division or	Attending r death. ector: After by the fune	Certification:	2 ☐ Accident investigat	ho.]Yes 2□No			
Ξ	or Att	TĮĮĮ.	3 Suicide 6 Could not 4 Homicide determine		At home, farm, st pecify)	treet, factory, office		28f. Location (City or To	Street and Numbe wn, State)	er or Rural Route Number,
Ω	urs af	S	¥12			de				
	Host 4 hor Fune tely f	ical	29a. Certifier Certifying (Check only one)	Physician: To the best of my kaminer: On the basis of exa	y knowledge, dea imination and/or i	nvestigation, in my	opinion, death occ	e, and due to the urred at the time,	date and place, a	and due to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29b. Signature and title of certifier	and manner stated.		29c Licer	ise number		29d, Date signed	d (Month, Day, Year)
	F.3 5 8	_	().//5	11/1/11	AN	1	2/17	2		12-67
	100		MAY C	-4,0		0	1641	0	3-1	
	500		30. Name and address of person wi	no completed cause of death	(Item 23a) (Type	Print)	1727	Cali	1 111.	5 21862
	CA	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		1/33	04/13)/ ///	5 / 10
	Regist		MAD 15		H A	and s				

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

MAR 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



-11 m

D14626

March 19, 2007

Registrar

DHMH 17 Rev 1/2001

State

WH-3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Renistrar's Signature

31. Date filed (Month, Day, Year) MAR 15 2007

			For 1 _ State	State of	f Marylan			nt of He e of D		nd Me	ental Hy		000	~ 7 ~ ~
		-	Registrar 1. Decedent's Name (First, Middle,	l ast)	-	Cer	illicai	COIL			2. Date of De	Reg. No.	- 211	3. Time of Death
	Physicia	ın	2017	_	1						Month	Day		10:20 P M
	/Medic	MACON'	Millard V. 4a. Facility Name (If not institution,		ouch		4h City	Town or l	Location of		March	8, 4c.	2007 County of Deat	10.20
	Examin	er	9919 Old Spring		nber)			sing		Dodin			ontgome	
	Funeral				7. Age (In yrs.	last birthday)	if Unde	r 1 Year	If Under 2	4 Hrs.	8. Date of Bi (Month, D			hplace (State or Foreign
	Director		577-50-3466	1⊠M 2□F	6	8 Yrs.	Months	Days	Hours	Min.	Month, D. Sarch	a <i>y, Year)</i> 27 . 19	38 Was	hington, DC
12.	and the same than		Usual Residence of Decedent											
	how at	,	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	a-f sl	cto	Md. Montgo	omery	Ke	ensingt	on							1XTYes 2 No
	or 28	Sire	10e. Street and Number				10f. Zi	Code				10g. Cit	izen of What Co	untry?
	23a ust b	Ta	9919 Old Spring	Road			2	0895					U.S.A.	
	r deg	Funeral Director	11. Marital Status	Armed Fo	edent Ever in U. rces?		Was Dece If Yes, spe	dent of His ecify Cubar	panic Orig n, Mexican,	gin? (Spec , Puerto F	cify Yes or N Rican, etc.)	0-	 Race - Ame Black, White 	
2	s afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1⊠Yes If Yes, Giv	2□No 195	7-	1 🗆 Yes	2 ⊠ No	Specify:				Specify: LIL	nite
	hour tural	d b	15. Decedent's	Year or Da	ates: 196	16a, Dece	rlant's I lsu	ial Occupa	tion			16h K	ind of Business/	
ņ	"nat	Completed	(Specify only highest	grade completed)		(Give	kind of w	ork done di ise retired)	uring most	of workin	g	100.10	Automot	
7	withi ene. than he M	E C	Elementary/Secondary (0-12)	College (1	-4or 5+)			ner				Ser	cvice St	
ν 5	filed Hygi other snt, t		17. Father's Name (First, Middle, La	ast)		.1			18. Mother	r's Name	(First, Middle	_		
/land	d be ental ked c	To Be	Millard	V. Cro	uch						Kath1	een	Curran	
<u></u>	shoul nd Ma marl	F	19a. Informant's Name/Relationshi		ucii	19b. Mailir	ng Addres	s (Street a	nd Number	r or Rura			or Town, State, 2	Zip Code)
2	od 2 lith au 27 is r trau		Margaret Elizabe	th Crouch	/Wife	9919	014 9	Sprin	g Roa	d. K	ensine	ton.	Marv1a	nd 20895
ก์	f Heal frem item othe	_	20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of	;		ate		ocation - City or	
9	Page: ent o nt: If i		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	e of H		•	í	/13/	2007	S 1 1 v	er Spri	no. MD.
Dallimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service) Gat				s of Facility		Vol Fu			
ŏ	permit Depar Impor any Ir once,		Kuan H	Seller	,	10) Eas	t Dee	r Pai					g,Md.20877
Ď.	-		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that c	aused the deat									Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition		rioscle									Onset and Death 6 Months
	/Medical		resulting in death)	u	or as a conseq		ncar	DIS	LUDU					O HOHENS
	Examiner		O TO BUILD HOLD TO BUILD THE	, Cerel	brovasc	ular D	iseas	se						2 Years
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	or as a conseq	uence of):								
	nd	Examiner	Cause (Disease or injury that initiated events	с										
Ď,	be executed ician and burial-transit	EX	resulting in death) Last	Due to	(or as a conseq	uence of):								
8/00,	ficate be executed physician and is the burial-transit	dical	,	d										
0	ertific ing p	യ	IF FEMALE:											
Ž Q	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	come pf pregnation in the 2 Feta	al death 3		regnancy					23d. Date of de Month	livery Day Year
-	the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9∐Unkn	ant at time of one	death 5	Other (s	pecify)						
ĭ	d by letach	Physician/M	Part II. Other significant condition	e contributing to d	eath but not res	ulting in the u	nderlying	rause nive	n in Part I		23e Did	tobacco	use contribute to	the cause of death?
Š.	w requires that the death certifichers signed by the attending I should be detached for use as	by	art II. Other significant conductor	is contributing to di	oddi Dat Hot Too	alang in the c	naonymg	oudoo givo	in in it care is					robably 4 □Unknown
0	requ	Completed												
Hecords	The law ate has be page 2 sh	nple									24a. Wa	opsy	prior to	utopsy findings available completion of cause of
		Co									1□ Yes	formed? 2 ⊠ No	death? 1 ☐ Yes	2 □ No
A II d	Physician: The law this certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				OA Othe		of Death	(Check only	one)		
0	Phys this al dir	To	1 ☑ Yes 2 ☐ No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o		07	4 LINUI		-		6 □Other (Spe	cify)
	Ilng After	ion	1 Natural 5 ☐ Pending	(Mon	th, Day Year)	Injury	" м	28c. Injury Work	ai ? ∕es 2 □ N		28d. Describe	riow inju	ry occurred	
IVISION	Attending For death. rector: After by the funeral	icat	2 Accident investiga 3 Suicide 6 Could no	t be 280 Place	of injury - At h	ome farm str					98f Location	(Stroot a	nd Number or B	ural Route Number,
\geq	or A	Certification:	4 Homicide determin	ed build	ing, etc. (Speci	fy)	root, racto	ry, onice		-		own, State		arai riodie Nambei,
_	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		29a. Certifier 1 🛣 Certifying	Physician: To the	best of my kno	owledge, deat	th occurre	d at the tim	ie, date an	d place, a	and due to th	e cause(s	and manner a	s stated.
	24 hos 24 hos Fur etely	Medical		xaminer: On the b										
	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and title of certifier	1/			25	c. License	number			29d. Da	ate signed (Mon	th, Day, Year)
	0+1		16	151/				D237	83			Мо	rch 9,	2007
l			30. Name and address of person w	no completed caus	se of death (Iter	n 23a) (Type,	Print)					1.19		
			Daniel J. Esposi					ve.#1	400 C	Chevy	Chase	, Md	. 20815	
j	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sign	ature a	ed 5							
	Registr	ar	MAR 13 2	THU/	A command	The state of the s	2050 5							

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic even." **Physician** /Medical

Physician

/Medical

Examiner

10a. State

Director

Funeral

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leted

Funeral

Director

Examiner

b

certificate has been signed by the attending physician and rirector, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division or Vital Records, P.O. Box 68760,

Ē	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Self Empl	oyed		Construc	tion
<u>e</u>	17. Father's Name (First, Middle, Last)			18. Mo	ther's Name (First, Mi	iddle, Maiden Surname)	
To Be Com	James Costantino			Am	elia Petra	ırca	
	19a. informant's Name/Relationship (7)	^{Type. Print)} (Spouse)	19b. Mailing Address (St	reet and Nun	nber or Rural Route N	lumber, City or Town, State,	Zip Code)
	Patricia Rosann	Costantino	11413 Scott	sbury	Terrace, G	Germantown, M	D 20876
	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ I		lace of Disposition (Name of emetery, crematory or othe	f place)	Date	20c. Location - City of	r Town, State
	4 Donation 5 Other (Specify		l Souls Cemet	ery	3/13/2007	Germantown	n, Maryland
	21. Signature of Funeral Service Licens	Derst	22. Name and A 10 East Gaithers	ddress of Fac Deer I burg,	cility DeVol Fr Park Drive MD 20877	uneral Home	
	23a Part1. Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final	one cause on each line.	n. Do not enter the mode or			ory arrest,	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	a Hyperkalemia Due to (or as a consequ					1 Day
		b. End Stage Re					1 Year
er	if any, leading to immediate	Due to (or as a consequ	uence of):				1 Ital
mi.	cause. Enter Underlying Cause (Disease or injury that initiated events	Diabetes Mel	litus Type I	I			Years
Exa	resulting in death) Last	Due to (or as a consequ					
g		d					
ledi							
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	i death 3 □Ectopic pregr			23d. Date of do	elivery Day Year
4	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the underlying caus	given in Par	rt I. 23e.	Did tobacco use contribute	to the cause of death?
d b	Congestive Heart					1 Yes 2 No 3 🔼 I	Probably 4 ☐Unknown
ete	Unnortonaion				249	Was an 24b. Were a	autopsy findings available
Comp	Hypertension					autopsy prior to performed? performed?	completion of cause of
Be	25. Was case referred to medical examiner?	112-1			ace of Death (Check o	only one)	
L P	1 100 22 110		ER/Outpatient 3 DOA			Residerice 6 □Other (Sp	ecify)
ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of lnjury M	Injury at Work? 1 ☐ Yes 2		ribe how injury occurred	
Medical Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specif	ome, farm, street, factory, of	fice	28f. Locati City o	ion (Street and Number or I or Town, State)	Rural Route Number,
edical	29a. Certifier (Check only one)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurred at t tion and/or investigation, in	ne time, date my opinion, o	and place, and due to death occurred at the	o the cause(s) and manner a time, date and place, and d	as stated. ue to the cause(s)
Ž	29b. Signature and title of certifier			ense numbe	,	29d. Date signed (Mor	
		h	1. D. D	53.	654	march 1	0,2007
	00 11						

State Registrar

1041

media & cester Drive, Rodwiller mo 20850

		For State Registrar	Otati	3 OI Waiyla	•		te of L				g. No.		
A 1 1 3	\$	1. Decedent's Name (First, Midd	le, Last)						2	. Date of Death Month	Day	Year	3. Time of Death
Physic /Medi			DO	RIS MARY	CONWAY					MAR		2007	5:34 A M
Exami		4a. Facility Name (If not institution	n, give street and	d number)		4b. Cit	, Town, or	Location of De	ath		4c. C	County of Dea	
		NATIONAL NA	VAL MED				BETH					MONTG	
Funeral Director		5. Social Security Number 158–14–7766	6. Sex 1 M 2 X		s. last birthday) Yrs.	Month:	er 1 Year Days	If Under 24 H Hours M	in.	Date of Birth (Month Day, 12,	1927	9. Bir C N.	thplace (State or Foreig ountry)
pu k		Usual Residence of Decedent 10a, State 10b, County	,	10c. (City, Town or Lo	cation							10d. Inside City Limits
sho	5		gomery		-		ille						1 X Yes 2 □ No
the A	ect	10e. Street and Number	gomery		T.	_	ip Code		-	10	Og. Citiz	en of What C	ountry?
with	급					101.12	,						
eath	era	5814 Wainwri		ue Decedent Ever in	U.S. 13.	Was Dec	2085 edent of Hi		(Speci	fy Yes or No-			erican Indian,
within 72 hours after death with the Maryland with 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28a-1 show he Madical Examiner is ust be notified at	by Funeral Director	1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	rried 1 1 1	od Forces? Yes 212 No s, Give or Dates:	ľ		ecify Cubai 2. No	spanic Origin? n, Mexican, Pu Specify:	ièrto Ri	can, etc.)	5	Black, Whi Specify: W	
A I A I D-0050 ad within 72 hours attagene. giene. or than "neturel", or the May Cal Exam.	ed		nt's Education		16a. Dece	dent's Us	ual Occupa	ition		1	I6b. Kin	d of Business	s/Industry
in 72	Completed	(Specify only higher	_ T		(Give	kind of v DO NOT	vork done d use retired,	uring most of	working				
y with	E O	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+) 1		Book	keepe	r			Ac	count	ing
ethose in		17. Father's Name (First, Middle	, Last)					18. Mother's I	Vame (First, Middle, M	Maiden S	Surname)	
ild be rice of the contraction o	To Be	Joseph Palz						Anne	Na	ash			
INCL YICHOLD IN 2 Should be file Ith and Mental Hy 77 is marked oth traumatic event	-	19a. Informant's Name/Relation			19b. Maili	ng Addre	ss (Street a	nd Number or	Rural	Route Number,	City or	Town, State,	Zip Code)
alth alth 27 is	١.	Michael Conwa	y / Husb	and	5814	Wai	nwrig	ht Ave	nue	, Rockv	ille	, MD 2	20851
Dallinore, Dermit. Pages 1 a Department of Hei mportant: if item nny injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (1	Place of Dispose cometery, cre	matory o	r other place	Mar	ch 07	13		•	r Town, State Virginia
DESILITIONE, METYIETIC ZIZIO-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "neturel", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinational be publified at any injury or other traumatic event, the Madical Examinational be publified at once.		21. Signature of Funeral Septice			2	2. Name	and Addres	s of Facility	Del	ol Fundithers	era1	Home	, 10 East
		23a, Part1, Enter the disease, of	or complications t	hat caused the de								,,	Approximate Interval Between
Physician /Medical Examiner	ər	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a										Onset and Death
tificate be executed gphysician and as the burial-transit	Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Du	ue to (or as a cons	equence of):								
death certif	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 🗀 l 4 🗆 f	s, outcome of precive birth 2 Fe Pregnant at time o	etal death 3	⊒Ectopic ⊒ Other	pregnancy (specify)				2	3d. Date of d Month	elivery Day Year
requires that the een signed by the hould be detached.		Part II. Other significant condit	tions contributing	to death but not i	resulting in the u	underlyin	g cause givi	en in Part I.					to the cause of death? Probably 4 □Unknow
HeC he law e has b age 2 st	Completed								_	24a. Was an autops perform	٧	24b. Were a prior to death?	autopsy findings available completion of cause of
vital r sicien: Th s certificate lirector, pag	Be	25. Was case referred to medic examiner?	al					26. Place of	Death	Check only on	43		
GD	2	1 Tes ZX No	Hospital:	1 XInpatient 2	☐ ER/Outpatie	nt 3 🗆	DOA Oth	er: 4 🗌 Nursin	ng Hom	e 5 🗆 Reside	nce 6	Other (Sp	ecity)
		27. Manner of Death 1X Natural 5 ☐ Pend	28a. I	Date of Injury (Month, Day Year)	28b. Time (Injury	of	28c. Injun Worl	at	28	d. Describe ho	w injury	occurred	
l or Attending after death. Director: After din by the fune	ertification:	2 Accident inves	tigation d not be	Place of Injury - A building, etc. (Spe	t home, farm, st	M reet, fact		Yes 2 □ No	28	If. Location (St City or Town	reet and	d Number or I	Rural Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai Cer	29a. Certifier Check only 2 Medics	al Examiner: On	To the best of my	knowledge, dea ination and/or it	th occurr	ed at the tin	ne, date and p	lace, ar	nd due to the ca	ause(s) ate and	and manner and de	as stated. ue to the cause(s)
hin 2 the the	Med	29b. Signature and type of contin		manner stated.			29c. Licens	number		ر.	9d. Date	signed (Mo	nth, Day, Year)
Vails	-	Zab. Signature and tine of certif		han				4801A (IN)	-	5	9	2007
10		30. Name and address of person	n who completes	cause of death /	tem 23a\ (Tuoo	Print)				AVAL ME	DIC	AL CEN	· ·
						,				D 20889			
S	ate	DOUGLAS G. H 31. Date filed (Month, Day, Yea		OR MC (32. Sgistrar's Sig	JSN gnature				21 FI	_ =000)			

			1- State of Maryland / D		artmen rtificat			and Me	_	giene Reg. No			09767
	Physici		Decedent's Name (First, Middle, Last) Laurie A. Connor						2. Date of De Month Iarch 1		2007 Yea	ar	Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or	Location of		idion 1	- 1	. County of D		:00 a w
	() ()		Carroll Hospital Center 5. Social Security Number 6. Sex 7. Age (In vrs. last bin		estmi			24 Um			Carr		
	Funeral Director		1 M OFF	Yrs.	Months	Days	Hours		8. Date of Birt <i>(Month, Da</i> [uly 9 ,	y, Year, 19:	21 9.1	Country) Mary 1	(State or Foreign Land
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Lo	cation							10d. I	nside City Limits
	Mary a-f sho fried a	tor	Maryland Carroll	Fin	ksbur	g						1	1 ☐ Yes 2 ☐ No
	ith the	Directo	10e. Street and Number		10f. Zip	Code				10g. Ci	tizen of What	Country?	<u>-</u> .
	sath w		629 Ridge Road 11 Marital Status 12 Was Decedent Ever in U.S.	110.1	Man Danas	210	048	-i-0 (0	16.37		USA		adian
36	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23b or 28a-f show matte event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 1 Yes, 2 1 1 Never Married 2 If Yes, 2 1 1 Yes, 3 1 1 Yes, 3 1 1 Yes, 3 1 1 Yes, 3 1 1 Yes, 3 1 1 1 Yes, 3 1 1 Yes, 3 1 1 Yes, 3 1 1 Yes, 3 1 1 Yes, 3 1 1 Yes, 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		was Deced If Yes, spec 1 ☐ Yes 2		spanic On in, Mexicar Specify:	gin / (Spec 1, Puerto R	ify Yes or No- lican, etc.)		14. Race - A Black, W Specify: W	/hite, etc.	idian,
9	2 hour atural cal Ex		15. Decedent's Education 16a.		dent's Usua					16b. K	(ind of Busine		у
212	ithin 7; ne. han "n e Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of wor DO NOT us		during mos)	t of working	g				,
d 21	Hygie Hygie Ither th		12 L	ibr	arian	1	18. Mothe	r's Name /	(First, Middle,	Maider	CIA	A	
lan	should be and Mental I s marked of	To Be	William A. Beall						nia Mu				
Maryland 21215-0036	es 1 and 2 should bot Health and Ment Item 27 is marked rother traumatic er		19a. Informant's Name/Relationship (Type. Print) William Joseph Connor, Jr./ Son	Mailin 629	ng Address Ridg	(Street a	and Number	er or Rural F in ks	Route Numbe burg,	er, City o	or Town, State 21048	e, Zip Cod	le)
Baltimore,	Pages 1 a nent of He int: If Item		20a. Method of Disposition 1	y, cren	natory or o	ther place		Da March	12		ocation - City		
alt	permit. Pages Department of I Important: If It any Injury or o		21. Signature of Funeral Service Licensee						uneral		elphi, ne Inc.		Tand
n	9 3 E 6 9		J. Ken Stile	50	0 Uni	vers	sity 1	Blvd,	W., S	ilve		ing,	MD 20901
ä.			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on ear Lline. Immediate Cause (Final	ot ente	er the mode	e of dying	g, such as	cardiac or	respiratory ar	rest,		Inte	oroximate erval Between set and Death
	Physician /Medical		disease or condition resulting in death) Due to (or e.g. consequence of the consequence	of):								100	iy 5
	Examiner		Sequentially list conditions, b. Myccovd	la	Q Z	nfa	reti	20				a	245
	nsit	Examine	Sequentially list conditions, to the sequentially list conditions, to the sequential seq	off)r	M.		rcti						11 11
o O	e execuan and and rial-tra		resulting in death) Last C. Due to (or as a consequence of	of):	7-10	195						1	rancy_
09/8	icate be executed physician and s the burial-transit	dical	d										
POX 6	leath certific attending p	0	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy								23d. Date of	delivery	
	the death certificate be executed by the attending physician and ached for use as the burial-transit	Physician/M	in the past 12 morths? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pro						Month	Day	Year
ds, r	sician: The law requires that the dicertificate has been signed by the rector, page 2 should be detached	δ	Part II. Other significant conditions contributing to death but not resulting in	the ur	nderlying ca	ause give	n in Part I.			bacco i			use of death?
ecords,	law red as beel 2 shou	Completed							24a. Was a		24b. Were	autopsy f	indings available
ב	: The cate had page	Com							autop perfor 1□ Yes	med?	death	1?	tion of cause of No
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ם ר	ig Phy ter this neral d	n: To	27. Manner of Death 28a. Date of Injury 28b. T			Bc. Injury Work	4 LI NU		e 5 🗆 Resid 3d. Describe h			(pecify	
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2	al or At s after d il Direct ed in by	Certification:	3 Suicide 6 Could not be 4 ∏ Homicide determined 28e. Place of injury - At home, far building, etc. (Specify)	m, stre	et, factory	, office		28	f. Location (S City or Tow			Rural Ros	ute Number,
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	, death	occurred a	at the tim in my op	ne, date an pinion, dea	d place, ar th occurred	nd due to the o	cause(s date an) and manner d place, and c	as stated	cause(s)
	To the	Me	29b. Signature and title of certifier			. License			ı		te signed (Mo	onth, Day,	Year)
,	ذا	1	30. Name and address of perso, who completed cause of death (Item 23a) (7	Two !	Print)	Do	58	137		3	/12/2	っつ	
سي			Willow Kus 295 Stone Ac		5 + 3	307	, ii	rest	nocte	-, 1	us z	115	7
	Sta Registr		31. Date filed (Manth, Day, Year) 2007	508	di)					,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** p^{M} Alicia Castellanos March 9, 2007 9:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12012 Berry Street Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 € F Director 101-64-9770 76 July 27, 1930 | El Salvador Usual Residence of Decedent death with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12012 Berry Street 20902 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or item any injury or other traumatic event, the Medical Examinatione. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1∰Yes 2□No Specify: Salvadoran Baltimore, Maryland 21215-0036 White þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 6 Laborer Garment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jose Maria Rodriquez Victoria Castellanos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vilma Diaz/ Daughter 12012 Berry Street, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State March 13 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licens Francis Address Corlins Funeral Home Inc. dum auglas 500 University Blvd, W., Silver Spring, MD 20901 a. Part1. Enter the isease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis Days /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Days Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖔 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? 2 🔀 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5XX Residence 6 Other (Specify) Hospital: 1 Yes 2X No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32332 March 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, M.D 9801 Georgia Avenue, #220, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 13

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MEND#23a(a)perMD3/14/07, HMW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Irene Victoria de Leon /Medical 4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Center 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 19,1944 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New Jersey 219-42-4199 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at any Injury or other traumatte event, the Medical Examiner must be notified at Maryland 1 ☐ Yes 2X No Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1330 Hill Born Drive 21076 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (%12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Cassese Laura Lanzara 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1330 Hill Born Drive Hanover, Maryland 21076 19a. Informant's Name/Relationship (Type. Print) Paul E. de Leon -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/12/2007 Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) Bonald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee Donald 4400 Powder Mĭ11 Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complicity in situations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ischemic Bowel /Medical Due to (or as a consequence of): Examiner Lntos tiva Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 I Inknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ faction 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed History 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an has re out Attending Physician: director, 25. Was case referred to medical examine? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral (28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife 2 77867

State Registrar 31. Date filed (Month

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MD

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2007

ted cause of death (Item 23a) (Type, Print) 4701 Fandolph Road # 216

xxulle

and manner stated

32. Registras Signature

andhe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Year

2007

Race - American Indian, Black, White, etc.

White

Month

29d. Date signed (Month, Day, Year)

BALTIMORE, MD Z/ZD

Day

Year

Coall PM

1 ☐ Yes 🏖 ☐ No

Birthplace (State or Foreign Country)

State

Registrar

To the

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SOUTH GREENE ST,

29c. License number

18586

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MABLE MARCH 5, Μ. DICKEY 2007 2020 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ANCHORAGE NURSING & REHAB CENTER SALISBURY WICOMICO tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3/2/1919 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗙 F 221-01-2102 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene.
and: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any or other transmisser in the Medical Examinar matter in other transmisser nothing as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 105 Times Square 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritat Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Marion Mills Louise Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dickey Jr./son 29791 Deer Harbor Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 IX Cremation 3 ☐ Removal from State permit. Page Depertment o Important: If eny injury or once. 4 □Donation 5 □Other (Specify) 3/13/07 Salisbury Crematory Salisbury, MD Signature of Funeral Service Licensee 22 Name and Address of Facility Holloway Funeral Home Professional Association Holloway Funeral Home Profesor Soll Snow Hill Rd., Salisbur Shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 20 No 1 ☐ Yes : After this certification and transfer of the sector, to 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Intury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗍 Suicide 6 Coutd not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 247094 NAKW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD NATESAN 1415 5. DIVISIUN Vel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ROBERT Defibaugh 1:27 A M Paul 2007 MARCH 20, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CECIL PERRY POINT VA MARYLAND HEALTH CARE SYSTEM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Oct. 13, 1939 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F Pennsylvania Director 210-28-4278 67 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ms 23a or 28a-f shor must be notified at 1 ☐ Yes 2 No Director VA Loudoun Potomac Falls 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4Webley Court U.S. of A. 20165-5672 Funeral ural", or Items 2 I Examiner mu Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. d 2 should be filed within 72 hours after the and Mental Hygiene.
27 Is marked other than "natural", or Ite traumatic event, the Medical Examine. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor/Project Mang. _Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Mabel P. Twigg 2 Carl Francis Defibaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Is r 4 Webley Ct. Potomac Falls, VA 20165 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. Ruth Elaine Defibaugh 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/23/07 |Alexandria, VA Metropolitan 21. Signature of Funeral Service License 22. Name and Address of Facility Loudoun Funeral Chapel 158 Catoctin, Cr. Leesburg, VA 23a. Part1. Enter the dease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filtere. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S DEMENTIA **Physician** UNKNOWN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ SEIZURE DISORDER 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No PERIPHERAL VASCULAR DISORDER 24a. Was an autopu performed : 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 TYes 2 TNo Il Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours are
To the Funeral Dir 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) omella MARCH 20, 2007 D30272

30

DHMH 17 Rev 1/2001

State Registrar THOMAS S. MILLER, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD. 21902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

MAR 2 8 2007

			1 - For State of N	/laryland		artment of Health and		giene	2007	
н			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	C-13-14	3. Time of Death
	Physicia /Medic		Anna Marie De	egan			Month March 1	.1, Day	OO7	11:00 a M
Š	Examin		4a. Facility Name (If not institution, give street and number	ir)		4b. City, Town, or Location of Deat	h	4c. 0	County of Death	1
******		-41	Hillhaven Nursing Center			Adelphi			ince Ge	
	Funeral		1 □ M 2 🗣 F	Age (In yrs. la	s <i>t birthday)</i> Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Da	y, Year)	Cot	nplace (State or Foreign untry)
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	yland Iow at		10a. State 10b. Counfy	10c. City,	Town or Lo	cation				10d. Inside City Limits
	a-fst	ctor	Maryland Montgomery	Sil	lver S	Spring				1 ☐ Yes 2 ☐ No
	or 28 e not	Director	10e. Street and Number			10f. Zip Code		10g. Citiz	en of What Cou	untry?
	ath w	ral	12919 Autumn Drive			20904			USA	
	er dea	Funeral	11. Marital Status 12. Was Deceder Armed Force	s?	. 13.	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	. 1	 Race - Amer Black, White 	
5	rs aft	by F	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Dates			1 ☐ Yes 2 ☐ No Specify:			Specify: Whi	te
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213	within 72 iene. • than "n the Medi	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40	or 5+)	(Give life. L	kind of work done during most of wo DO NOT use retired)	rking			
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yla	2 should be n and Mental is marked raumatic ev	٩	John J. Moore			Mary Sull				
Mai	12sh hand 7ism traum		19a. Informant's Name/Relationship (Type. Print) George Jay Deegan, III/ Se	on		ng Address <i>(Street and Number or Ri</i> D Autumn Drive, S				•
a,	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	20b. Pla	ice of Dispo	sition (Name of	Date		ation - City or 1	
aitimor	Pages nent of I int: If its iry or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place) ; n Nat'l Cemetery	March 19	1		
	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		24	Name and Address of Eachithin				Virginia
ñ	any per		dans & Oarl.			500 University B1				na. MD 2090
ľ			23a. Part1. Inter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death.						Approximate Interval Between
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Þ	/Medical		resulting in death)	as a conseque		1100240110				2 20,13
	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or a							
	per isit	Examine	if any, leading to immediate Due to (or a Cause (Disease or injury)	as a conseque	ence ot):					
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000	tificat g phy as the	ledi								
gox	th cer endin	3n/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcor 1	me pf pregnand 1 2 □ Fetal o		Ectopic pregnancy		23	3d. Date of deli-	*
	ed for	sicis	In the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant	t at time of dea		Other (specify)			Month	Day Year
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T G	has ge 2 s	Completed	Alzheimer's Disease				24a. Was autop	SV	prior to c death?	topsy findings available ompletion of cause of
\IIa \	in: The ifficate or, pa		25. Was case referred to medical			Of Place of De		rmed? 2 No	1 ☐ Yes	2□ No
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SION	endir ath. or: Af he fur	atio	2 ☐ Accident investigation	23, 123,	,,	M 1 ☐ Yes 2 ☐ No				
<u>"</u>	or Atte ter de irecte n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building,	injury - At hom etc. (Specify)	ne, farm, str	eet, factory, office	28f. Location (5 City or Tox	Street and vn, State)	Number or Ru	ral Route Number,
ב	urs af		Contificing Physicians Table he	-t -f l	lodes death	a construed of the time of the end of the				
	Hos 24 ho Fun etely f	Medical	29a. Certifier (Check only one) 1— Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	s of examination	on and/or in	vestigation, in my opinion, death occ	e, and due to the urred at the time,	date and	and manner as place, and due	to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	29b. Signature and little of sertifier	<u> </u>		29c, License number		29d. Date	signed (Month	, Day, Year)
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	(0		30. Name and address of person who completed cause o							
						d Drive, #205, S	ilver Sp	ring	, MD 20	901
	Sta Registr		31. Date filed (Month, Day, Year) MAR 13 2007	strar's Signatu	ire	auti)				

		1 _ State	aryland / Dep	artment of H rtificate of L			21111	7 09776
基 协 4		Registrar 1. Decedent's Name (First, Middle, Last)	Ce	Tillicale of L	Jean	2. Date of Deat	eg. No	3. Time of Death
Physic		Hyder S. Edwa	rds			Month	18 2007	
/Medi Exami		4a. Facility Name (If not institution, give street and number)	143	4b. City, Town, or			4c. County of De	
LXuiiii		221 Honeysuckle Lane		Union	n Bridge		Carrol	1
Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
Director		166-12-9741	88 Yrs.			(Month, Day,	, 1918 Te	nnéssee
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
Mary -f sho ied a	ţo	Maryland Carroll		Union Br	idae			1 X Yes 2□No
n the r 28a r notif	Director	10e. Street and Number		10f. Zip Code	ruge	1	0g. Citizen of What C	Country?
th wit 23a o sst be	a D	221 Honeysuckle Lane		21	791		U.S	.A.
r dea	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
s affe	by Fi	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes, 2 ☐ IIf Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	,	Specify:	
IN CIL IS-UUSD filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show only, the Medical Examiner must be notified at		15. Decedent's Education	1941-45	dent's Usual Occupa	ation	1	16b. Kind of Busines	hite s/Industry
7. iii 7. iii 7. iii 7. iii 7. iii 7. iii 7. iii 7. iii 7. iii 7. iii 7. iii 7. ii 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	kind of work done d DO NOT use retired)	lurina most of worki	ng		,
d with giene greene ar tha	mo.	12 5	(civil engi	neer		roads & b	ridges
/tand	Ba Ba	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	Maiden Surname)	
aryiarno should be i and Mental I s marked ol umatic eve	ျှ	David Samuel Edwards Sr.	7		lda F.			
Mar d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)					; City or Town, State,	•
Heati		Mary Margaret Edwards/ wife	20b. Place of Dispo	doneysuck l			Bridge, MD 20c. Location - City o	
Pages nent of h		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	matory or other place	e) :			
Dailling Permit. Pages Department of mportant: If it my injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Pipe tree	ek Cemeter 2. Name and Addres	y 3/22/2	200/ n	r. Linwoo	a, MD
Dail permit. Departi Imports any inj		Katharine O. Hartel	er e	E. Broad	Har: lway Unio	tzier Fu on Brido	neral Hom	e 91
		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	I the death. Do not en					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	1 CANUL	all (INI C	ANO	_	Onset and Death
/Medical		resulting in death)	a consequence of):					3 .7107-8
Examiner	L	Sequentially list conditions, if any, leading to immediate b. Due to (or as						
ed sit	nine	if any, leading to immediate Due to (or as cause. Enter Underlying Cause (Disease or injury	a consequence of):					
xecul al-trar	Examiner	that initiated events c.	a consequence of):					
icate be executed physician and sthe burial-transit	dical E	U d						
g phy as the	ledic	u.						
th cer endin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		⊒Ectopic pregnancy			23d. Date of de	
e dea he att	sici	1 Yes 2 No 4 Pregnant at		Other (specify)			Month	Day Year
w requires that the death certific been signed by the attending I should be detached for use as	Phy	g ☐ Unknown Part II. Other significant conditions contributing to death be	ut not reculting in the u	andorfuina couso aivo	n in Bort I	020 Did tob	anna una parteituta	to the course of death?
signe signe	by	Line Ro BARIO	at not resulting in the u	indenying cause give	ii iir Fait į.	1 □ Ye		to the cause of death? Probably 4 Unknown
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ne lav has ge 2 s	Completed					24a. Was ar autops perforr	v prior to	autopsy findings available completion of cause of
in: Ti ificate or, pa		25. Was case returned to medical			00 Plan (P. MI	1□ Yes 2	2 XNo 1 □ Ye	s 2 No
/sicia /sicia	To Be	examiner? 1 Yes No Hospital: 1 Inpatie	ent 2 ☐ ER/Outpatie	nt 3 DOA Othe	26. Place of Death r: 4 ☐ Nursing Hor	1	<i>e)</i> ence 6 □Other <i>(Sp</i>	enify)
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ital o								
To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of the desired passes	f examination and/or ir	th occurred at the time extigation, in my op	ne, date and place, a pinion, death occurr	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
o the	Mec	29b. Signature and title of certifier	ateu.	299. License	number	29	9d. Date signed (Mor	nth, Day, Year)
FSFO		• / /		16	20)/		3/10/1-	7
Tilled 1		30./Name and a dress of person who completed cause of d	eath (Item 23a) (Type,	Print)			1111	
8		Yousk-6917-9-55550	uth (co)	or Street	WESTM	iuster, t	1021157)
Sta			ar's Signature	A		-		
Regist		MAR 2 8 2007	No Mose					
DHMH 17 Rev 1/2	JUI							

			1 - For State Registrar	State of Mary		artment rtificate			and M		giene Reg. No.	107	09775
			1. Decedent's Name (First, Middle, Las	st)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medi		FRED ELLISON,							03	09	2007	10:00P M
}	Examir	ner	4a. Facility Name (If not institution, give	e street and number)		4b. City, T	own, or	Location of	of Death			ounty of Death	
			HRC MANOR CARE	7 8 50 //0	rem lant hinth days	LA If Under 1	RGO	If Under	24 Hrs	8. Date of Birt			EORGE S place (State or Foreign
п	Funeral Director		5. Social Security Number 6. S	9X 7. Age (/// 12 M 2□ F	yrs. last birthday)		Days	Hours	Min.	(Month, Day 06/07/	y, Year)	Cou	TH CAROLINA
			Usual Residence of Decedent							00/0//	1929	NOK	III CAROLINA
	ylanc		10a. State 10b. County		c. City, Town or Lo								10d. Inside City Limits
	B Ma	ctor	MD PRINCE	GEORGE 'S	CAF	'ITOL 1	HEIG	HTS					1 ☐ Yes 2 🌠 No
	death with the Marylan ms 23a or 28a-f show	Director	10e. Street and Number			10f. Zip (10g. Citize	n of What Cou	intry?
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36	or ite	by Funeral	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1XXYes 2 No If Yes, Give Year or Dates:		If Yes, speci	17	spanic On n, Mexicar Specify:	gin (Spo i, Puerto	ecify Yes or No- Rican, etc.)		Black, White	, etc.
21215-0036	72 hours neturel', old al Ex		15. Decedent's Ed		16a. Dece	dent's Usual	Occupa	ition	t of work	ina	16b. Kind	of Business/Ir	ndustry
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<u>Y</u>	D 8 8 5	2	FRED ELLISON		405-14-77		(0)	- 11/		LYDIA (- Codol
Mai	C		19a. Informant's Name/Relationship (7210	KING	SAR	M DR	ĮVE	al Route Numbe	st, City of i	OWII, State, Zi	p C00e)
	1 an Heali em 2 ther		EVELYN CLARKE/A		Ob. Place of Dispo	SSAS,	e of			Date	20c. Loca	tion - City or T	own, State
nor	0 0		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specific		FT. LINC		her place	9)	3/1:	7/2007	RT A1	DENCRII	oc MD
Baltimore,	_ 든 뿐 증		21. Signatore of Fuproral Service Licer				l Addr ≱4	ACRISHIA			7 BLADENSBURG, MD ERAL HOME OF MD, INC.		
B	permi Depa Impo any ir		J. P. Tha	shall									MD 20746
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not en	ter the mode	of dying	g, such as	cardiac (or respiratory ar	rest,		Approximate Interval Between
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P.O. Box	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pre ⊒ Other (spe		. =			230	d. Date of deliv Month	rery Day Year
	that the ned by the detache	by Ph	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	ınderlying ca	use give	n in Part I		23e. Did to	obacco use	contribute to	the cause of death?
rds	w requires baan sign should be	ed b	GOUT							1 🗆 1	/es 2□I	No 3∑ Pro	bably 4 □Unknown
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æ	m _ m	Eo									rmed?	death?	
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of V	Physiclan: this certificanal director,	70	examiner? 1 🗆 Yes - 💥 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DO	Othe	9r: 4 ∑ Nu	ırsing Ho	me 5 🗆 Resid	dence 6 [Other (Spec	ify)
		on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o		lc. Injury Work			28d. Describe h	now injury o	occurred	
sio	Attending r death. sctor: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be			М		∕es 2□	No	not Ition (Dave ed en el f	Street and Con	ral Route Number,
Division	or Atten after deat Diractor: in by the	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At nome, tarm, st pecify)	reet, ractory,	office			City or Tov		vullipel of Hul	ar noute wantber,
	e Hospitel 24 hours a e Funaral I etely filled		29a. Certifier 1 X Certifying Ph	ysicien: To the best of my	v knowledge, deal	th occurred a	t the tim	e. date an	d place.	and due to the	cause(s) ar	nd manner as	stated.
	T 4 IT @	edical	(Check only 2 Medical Examone)	niner: On the basis of exa and manner stated.	mination and/or in	vestigation,	in my op	oinion, dea	th occur	red at the time,	date and pl	ace, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c.	License	number	-		29d. Date s	signed (Month	, Day, Year)
)			900	ورور	0	D(0062	116			3/1	12/2007	7
2	(5)			completed cause of death			г DR	IVE,	GREI	ENBELT,	MD 20	0770	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 4 2007	32. Registrar's									

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** \mathbf{P}^{M} 2007 1:45 Nancy D. Ernst March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 405 East Main Street Middletown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Director May 1, 1930 Virginia 212-28-9131 76 Usual Residence of Decedent the Maryland 10c. Cify, Town or Location 10a State 10b. County 10d. Inside City Limits show r 28a-f sh notified a 1 Yes 2 No Directo Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r United States 405 East Main Street 21769 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White ð 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Newspaper Comptroller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alma Ashby John A. Deuterman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 405 East Main St., Middletown, MD 21769 David Ernst / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/15/2007 Frederick, Maryland Stauffer Crematory 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 2da. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. East only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any list in the cause in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine The law requires that the death certificate be executed physician a s the burlal-1 Due to (or as a consequence of) Box 68760. Physician/Medical attending ph for use as t IF FEMALE: 23c. if yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 14 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page perform certificate 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 2 4 Nursing Home 5 ■ Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft To the Funeral Di completely filled in 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 48/84 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Street Frederick, MD Elhamy Eskander, MD 501 W 31. Date filed (Month, Day, Year) State Registrar MAR 1 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0820AM 2007 uarch Harold Lee Ecton 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) May 13, 1938 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Days 1⊠M 2□F Months Hours Min Maryland 68 219-34-5068 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1√√Yes 2 No Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21742 1048 Beechwood Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 'Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Photo Processing Splicer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nina Ebersole Norman Ecton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1048 Beechwood Drive Hagerstown, Maryland Lana P. Reynolds - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery Mar. 17, 2007 Hagerstown, Maryland 21. Sonatur of Funeral Service Licensee OS Derend Aparen Faity Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial 4 Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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signed by the a d be detached for

page 2 s

After this certificate

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To the Hospital of within 24 hours at To the Funeral D

funeral

be executed

P.O. Box 68760,

Division or Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

"natural", or items 23a or 28a-f shov idical Examiner must be notified at

the Medical

or other traumatic event,

72 hours after

12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r

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permit. Pages 1
Department of H
Important: If ite
any Injury or ot

Baltimore, Maryland 21215-0036

Directo

Funeral

Completed

Be ၉

Examine Physician/Medical Completed by Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy 2 No

26. Place of Death Check onl one

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

	was case examiner? 1 Yes		o medical
27.	Manner of	Death	

1 Natural 5 Pending investigation

determined

1 Inpatient 28a. Date of Injury (Month, Day 6 □ Could not be

Hospital:

Malik

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 ER/Outpatient 3 DOA 28h Time of njury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier

2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title

29d. Date signed (Month, Day, Year) March 14, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

J5H-10

State Registrar

Medical

31. Date filed (Month 15 2007

32. Registrar's Signature

MD

Cappans Rd Boonsboro MO 21713 20311

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_	•	For State Registrar	ate of Maryland /		tificate of L			eg. No. 🤈 🏻	107	09778
	Physicia		1. Decedent's Name (First, Middle, Last)	rank Fillmar	าท			2. Date of Dea March	13 ^{ay} 20	00 ⁴ 7 ^{ar}	3. Time of Death 1:20 A M
	/Medic Examin	- 1	4a. Facility Name (If not institution, give stree Washington Adventi	and number) st Hospital		4b. City, Town, or Takoma	Location of Death			y of Death	ery
	Funeral Director		5. Social Security Number 6. Sex 1 M M	7. Age (In yrs. last	birthday) _	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan 9,	, Year)	Coun	lace (State or Foreign try)
	iand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation				1	0d. Inside City Limits
	e Mary a-f sh tiffed a	ctor	Maryland Prince Geo	rge's		Lä	anham				1√Yes 2 No
	death with the Maryland ms 23a or 28a-f show r must be notified at	al Director	10e. Street and Number 9101 4th Street			10f. Zip Code	0706	1	0g. Citizen of	What Coun	
36	s after dea ", or Items aminer mu	by Funeral	1 Never Married 2 Married 1	/as Decedent Ever in U.S. rmed Forces? Yes 2 □ No WWII Yes, Give ear or Dates:		/as Decedent of Hi Yes, specify Cuba □ Yes 2X No		pecify Yes or No- pecify Yes or No- pecify Yes		ace - Americ ack, White,	etc.
215-0036	be filed within 72 hours after death with the Marylar ntal Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed t	15. Decedent's Education (Specify only highest grade con	1	6a. Decede (Give k life. D	ent's Usual Occup kind of work done o O NOT use retired	during most of word)	king	16b. Kind of Business/Industry		
12.	e filed wi al Hygien other th vent, the	ပ္ပ	10th 17. Father's Name (First, Middle, Last)			Salesman	18. Mother's Nam	ne (Firet Middle		civate	
Ianc		To Be	Nicolas Fillmann					ne Trout			
Maryland	s 1 and 2 should b f Health and Ment Item 27 Is marked other traumatic e		19a. Informant's Name/Relationship (Type. F Ann Fillmann (Wife			Address (Street and Ath Street				n, State, Zip	Code)
Baltimore,	Pages 1 a nent of Hea int: If Item iny or othe		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State		ition (Name of patory or other place	i i	Date 5/2007	20c. Location	- City or To	
Balti	permit. Pages Department of Important: If I any Injury or once.		21. Signature of uneral service Licensee	me	22.	Name and Address	ss of Facility Re	endon/Ha	le Fune	eral H	lame
ľ			23a. Part1. Enter the disease, or comblication shock, or heert failure. List only one car		Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Du monary Due to (or as a consequent Acute	ce of):	erdeac	arm	et -			
ļ,	Ps.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events ct.	Due to (or as a consequen	ce of):	ferm	Wall	Mar	ct		-
68/60,	at the death certificate be executed by the attending physician and tached for use as the burial-transit	cal Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):			* + 1			
		Medical	IF FEMALE:								
C. Box	requires that the death cer een signed by the attendir hould be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	yes, outcome pf pregnancy □Live birth 2 □ Fetal de □ Pregnant at time of deatl □ Unknown	eath 3 🗆	Ectopic pregnancy Other (specify)				ate of delive Month	ery Day Year
٦.	w requires that the state of th	þ	Part II. Other significant conditions contribu	ting to death but not resultin	ng in the un	derlying cause give	en in Part I.				ne cause of death?
Records ,		Completed						24a. Was a autop perfor	an 24b sy med?	o. Were auto prior to co death?	psy findings available mpletion of cause of
VItal	60 57	Be Co	25. Was case referred to medical				26. Place of Dea	th (Check only or	2X No	1 🗆 Yes	2□ No
or <	Physiclan: r this certific ral director,	To E	examiner? 1 ☐ Yes 2 No Hospi	1 Inpatient 2 ER		3 DOA Oth	4 LI Nursing H	ome 5□ Resid	ence 6 🗆 O	ther (Specif	jy)
lon	Attending P r death. ector: After it	ation:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	Ba. Date of Injury (Month, Day Year)	Bb. Time of Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe h	ow injury occu	urred	
Division	in Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	Be. Place of injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and Nun n, State)	nber or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical ((Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tir restigation, in my o	me, date and place opinion, death occu	e, and due to the durred at the time,	cause(s) and r date and place	manner as s e, and due t	tated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1-		29c. Licens			29d. Date sign		
_	(DI		30. Name and address of person who compare	Ko	2a) /T		22 1/1		03	114	1007
K	1 Wg		7 Holds Y Ko	MD Hoo	GANC	Print) Klack N	2 302	Lanhan	4 14	1 20	706
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	BI				-		

		4	For L State	State of Maryl					0.7	mg yes was		
			Registrar 1. Decedent's Name (First, Middle, Last,	1	Cer	tificate of L	Jeath	2. Date of Deat	eg. No.		3. Time of Death	
	Physicia /Medic	in	SAUL		FEUER			Month March	11, 20	Year 07	3:00 P M	
	Examin	24	4a. Facility Name (If not institution, give	street and number)						4c. County of Death		
			Citizens Nursing 5. Social Security Number 6. Se		yrs. last birthday)	Frede	erick If Under 24 Hrs.	8. Date of Birth		deric	olace (State or Foreign	
	Funeral Director			A	yrs. last birtiday).	Months Days	Hours Min.	(Month, Day, April 11	, Year)	Coul	York	
	D ,		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Loc	ration					10d. Inside City Limits	
	laryla shov ed at	5	Maryland Freder:		Freder						1 □Yes 2 No	
	the N 28a-i notifi	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cou	ntry?	
	h with		2504 Shelley Cr	./ Apt. 3-D		21702	2		United	l Sta	ates	
	ems :	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ice - Americack, White,		
2	should be filed within 72 hours after death with the Maryland rund Mental Hygiene. Ind Mental Hygiene. Inakted other than "natural" or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates: WW	тт 1	∏Yes 2X No	Specify:		Spec	_{ify:} Whi	ite	
	2 hour	ted	15. Decedent's Edu	ucation	16a Dagge	lent's Usual Occupa	ation	ding 1	16b. Kind of I	Business/Ir	ndustry	
2	be filed within 72 ho tral Hygiene. d other than "natu event, the Medical	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of NOT use retired				_		
7	ed wil	Con		2	Broa	adcast En	gineer 18. Mother's Nam				Network	
2	ihould be filed id Mental Hygi marked other matic event, t	Be	17. Father's Name (First, Middle, Last) Louis	Feuer			Fannie					
Ž	nd 2 should tath and Ment 27 Is marked or traumatic e	P.	19a. Informant's Name/Relationship (7)		19b. Mailin	g Address (Street a			Stei r, City or Town		p Code)	
2	nd 2 alth a 27 Is r tra		Irene Feuer / wife		2504	Shelley	Cr./Apt.	3-D./Fre	ederick	, MD	21702	
ָרָ ב	He He		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ I		Ob. Place of Dispo			Date	20c. Location		own, State	
	Pages ment of I ant: If Ite ury or o		4 □ Donation 5 □ Other (Specify) J		m.Gardens			Olney,			
חשב	permit. Pages Department of Important: If II any injury or o		21. Signature of Funeral Service Licens	On land		2. Name and Address 621 Oposs						
			23a. Part1. Enter the disease, or comp	olications that caused the	, —					· , 11D	Approximate Interval Between	
	Physician		shock, heart failure. List only of Immediate Cause (Final disease or condition	ine cause on each line.	hum	- 1.	een	,			Onset and Death	
	/Medical		resulting in death)	a. Due to (or as a co	nsequence of):		een				Wys	
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b								
	bed nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence oi).							
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a co	ensequence of):							
0/00,	cate be executed physician and the burial-transit	dical		.d								
Þ			IF FEMALE:					-				
מכא	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1☐Live birth 2☐ 4☐Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	/			Date of deliv Month	very Day Y <i>e</i> ar	
5	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	e or dealir 3							
ŗ	s that ned by	by Ph	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use co	ntribute to	the cause of death?	
cords,	en sig							1 🗆 \	′es 2. No	3 ☐ Pro	bably 4 ☐Unknown	
ပ ပ	ding Physician: The law requir n. After this certificate has been s' funeral director, page 2 should	Completed						24a. Was autop	sy	prior to c	topsy findings available ompletion of cause of	
<u> </u>	: The cate h	Con							rmed? 2 No	death?	2 No	
V Ital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	2.55.0	th all DOA Oth	or /	th (Check only o	,			
5	Phys er this eral di	٦. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier			lome 5 ☐ Resid			ary)	
0	Attending r death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		ear) Injury		Yes 2 □ No					
JIVISION	or Atte fter de Sirecto in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (S	- At home, farm, str Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Nur vn, State)	mber or Ru	ral Route Number,	
_	spital on neral D			ysician: To the best of m								
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical	one)	niner: On the basis of exa and manner stated	l.				20.1 D.1.	1 /2 / 1	D. W. d	
	Voit To	2	29b. Signature and title of certifier	1///	lin	29C. Licens	2/14/6		29d. Date sig	/ 2	Of 7	
•	AV.		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	6//6	-	3/10	10		
0	41,		Francis E.	Berbe	mo	300 W	29171	7) Fr	deri	de.	100 T	
		ate	31. Date filed (Month, Day, Year)	32. Fegistrar's	Signature	harles						
	Regist	rair	MAR 1 5 2	UUI KARAKE	1 10 /5)	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	ale of Warylan		rtificate o	f Death		Reg. No.	1 03780
	Physicia	an	1. Decedent's Name (First, Middle, Last) Isaac A. Fisher					2. Date of De Month March	07 ^{Day} 2007	3. Time of Death 7:00 a M
	/Medic	al	4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town	, or Location of Death		4c. County of	
	LAGIIIII	ici	304 Martins Cove Rd			Annapo1			Anne Ar	
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. 2□ F	/ast birthday) 76 Yrs.	If Under 1 Yea Months Day		8. Date of Bir (Month, Pa 3/9/19	$\frac{1}{30}$ $\frac{9}{1}$	Birthplace (State or Foreign Country) New York
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Mary a-f she	ţo	MD Anne Arunde	1 Anı	napolis	5				1 □Yes 2 No
	ith the	Director	10e. Street and Number			10f. Zip Code	9		10g. Citizen of Wha	at Country?
	ath w	ral	304 Martins Cove Rd		10	214			USA	American Indian,
350	should be filed within 72 hours after death with the Maryland not Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 ▼ Married	Vas Decedent Ever in U vrmed Forces? ⊠Yes 2 No 194 Yes, Give ear or Dates: 19	48-	was Decedent of If Yes, specify C 1 ☐ Yes 2X N	of Hispanic Origin? (Spuban, Mexican, Puerto Io Specify:	ecity Yes of No Rican, etc.)	Black,	White, etc. White
9500-61212	72 hou 'natura dical E	Completed	15. Decedent's Educatio (Specify only highest grade cor	n npleted)	16a. Dece	dent's Usual Oct kind of work do	cupation ne during most of work ired)	king	16b. Kind of Busin	iess/Industry
12	within ene. than "	mple		College (1-4or 5+)	Offic		ired)		United St	ates Navy
0	filed Hygie	Be Co	17. Father's Name (First, Middle, Last)		.1		18. Mother's Nam	e (First, Middle	, Maiden Surname)	<u> </u>
/land	Aental Aental rked tic ev	To B	Perry Mayers Fisher				Mary Eli	Lzabeth	Green	
	2 short and h is ma auma		19a. Informant's Name/Relationship (Type. I	Print)	ı	-	et and Number or Ru			
	s 1 and 2 of Health a Item 27 is		Frances Fisher/Wife 20a. Method of Disposition	20h		artins C		napolis Date	20c. Location - Cit	
Baltimore,	permit. Pages 1 and 2 should be f Department of Heath and Mental I Important: If Item 27 is marked of any injury or other traumatic even once.		1 Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	vai irom State	lingtor	osition (Name of matory or other n Nation	al 4/5/	2007	Arlingtor	n, VA
Rai	permit Depar Impor any In		21. Signature of Funeral Service Licensee				dress of Facility Har y Ave. Ann	_		
į			23a. Part1. Enter the disease or complication shock, or heart failure. List only one call immediate Cause (Final	ons that caused the dea			-			Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	Due to (or as a consec	quence of):	210		amo		
	Examiner		Sequentially list conditions b. —							
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):					
6	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):		 			
68/60,	e be e /sician e burit	calE	d							
		Aedical	IE ECHALO:							
.C. Box	The law requires that the death certific te has been signed by the attending by tage 2 should be detached for use as	Physician/N	in the past 12 months?	f yes, outcome pf pregn 1 □Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	⊒Ectopic pregna ⊒ Other (specify			23d. Date of Month	
7	w requires that is been signed by should be detail	by	Part II. Other significant conditions contrib	uting to death but not res	sulting in the u	inderlying cause	given in Part I.			ute to the cause of death?
Vital Records,	The law requate has been page 2 shou	Completed						24a. Was auto perfe	psy pric	ere autopsy findings available or to completion of cause of ath?
ta	(0		25. Was case referred of medical				26. Place of Dea	th (Check only)]Yes 2□No
	Physician: rthis certifica ral director, p	To Be	examiner? 1 Yes 2 No Hosp	ital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA	Other		idence 6 □Other	(Specify)
Division or	Attending Ph death. ictor: After th y the funeral		1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	8a. Date of Injury (Month, Day Year)	28b. Time o Injury		njury at Vork? ☐ Yes 2 ☐ No	28d. Describe	how injury occurred	
Divis	fter or Sire	Certification:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of injury - At h building, etc. (Spec	nome, farm, st ify)	reet, factory, offi	ce		(Street and Number wn, State)	or Rural Route Number,
	To the Hospital within 24 hours at To the Funeral Completely filled	Medical	29a. Certifier 1							
	To the within To the comple	Mec	29b. Signature and title of certifier	1,1		29c. Lic	ense number	082	29d. Date signed (Month, Day, Year)
)		1	XI TO	top 2		1	10055	0 0 5	3	-12.07
١	INLL	,	30. Name and address of person who complete the second sec	4	m 23a) (Type,	Print)	e Ll.	5 101	te an	Our m
		ate	31. Date filed (Month, Day, Year)	32. Régistrar's Sign		0.013	C May	. , _),		21401
	Regist	rar	MAR 1 2 200	Pagas a	FE A	mark o				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10am rand per inf e877 3-27-08 Mt/rehygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 **Physician** Year Montena HAYE +ORTUNE 2047PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA 5 ALISBURY REGIONAL MEDRAL CENTER NICOPICO 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day/ Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F 96-28-0514 Director Usual Residence of Deceden the Maryland 10a. State PA. 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Deleware Chester **Funeral Director** 1 Yes 2 No 10e. Street and Number 1431 M L King Way 10f. Zip Code 10g. Citizen of What Country? 19013 with "natural", or Items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 📈 o Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Social Services al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 lerica worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Health and Mental FORTUNE ٩ FORTUNE Juprec 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26686 Porter Mill RUAD Hepron Department of Heah Important: It Item 27.
any injury or off-SISTER Marvella Koums 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Incremation 3 ☐ Removal from State Clester Township! HAVEN MENDEIAL CENTURY 3/23/2007 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gennie Smith Funeral 917 West Isabella St. Salisbury, 21. Signature of Funeral Service License rescella Kninds 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEART FATHURE CONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SYNDROME SJOGKEN'S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner TRAS law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physician for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Mo 24a. Was an certificate has autopsy performe 2 No Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 5 ☐ Pending investigation or Attending 1 Natural (Month, Day Year) death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: Hospital completely

Maryland

altimore,

State Registrar 29b. Signature and title of certifier

31. Date filed (Month Ray

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1°5 2007

MUJORO Begistrar's Signature

29c. License number

ST. SLUTE 504B, SAUSBURY

29d. Date signed (Month, Day, Year) 0

		4	For State Registrar	State of Maryland	-	rtment of tificate of			giene Reg. No. 007	09782
	Physicia	an	1. Decedent's Name (First, Middle, Last) Henry _bhn	Fied		•		2. Date of Dea Month MARCH	Day Yea 200	3. Time of Death
10 mg	/Medic Examin		a. Fecility Name (If not institution, give st	reet and number) F CECIL COV	NTY	4b. City, Town, ELKT	or Location of Dea	17 .71 .	4c. County of De	eath
8	Funeral Director		221-60-0313	7. Age (In yrs. la M 2 F 74	st birthday) Yrs.	If Under 1 Yea Months Day			y, Year)	Birthplace (State or Foreign Country) WYORK
	yland	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
	Ba-feh	ctor	Maryland Cecil	Ch	ilds					1 □ Yes 2 ሺ No
	with th	Funeral Directo	10e. Street and Number	1		10f. Zip Code	4		10g. Citizen of What United	,
	ne 23	era	1120 Blue Ball Ro	2 Was Decedent Ever in LLS	S. 13. V	21910 Vas Decedent of	Hispanic Origin? (Specify Yes or No	- 14. Race - A	merican Indian,
036	d within 72 hours after death with the Maryland jiene. Then "natural", or iteme 23s or 28s-f ehow I're Mudicel Evant, at must be notified at	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	If	Yes, specify Cu ☐ Yes 2 N	ban, Mexican, Pue	rto Rican, etc.)	Specify: _	hite, etc. White
Maryland 21215-0036	in 72 ho "natur	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	ent's Usual Occ kind of work don OO NOT use reti	e during most of we	orking	16b. Kind of Busine	ss/Industry
212	d within giene er then "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Bro	ther			Religio	ous
nd	be filed stal Hygie od other event, L	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
ryla	2 should be and Mental is marked c	은	George M. Fiegl 19a, Informant's Name/Relationship (Type	ne Print)	19h Mailin	n Address (Stre		e Leisin	g er, City or Town, State	e. Zip Code)
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		blates of St. Franc		i i				gton, Delay	
Baltimore,	permit. Pages 1 a Depertment of Her Important: If Item any injury or othe	li	20a. Method of Disposition 1 ∰ Burial 2 ☐ Cremation 3 ☐ Ro	emoval from State	emetery, cren	sition (Name of natory or other p	l Liai	ch 23,	20c. Location - City	
ltin	nit. Pa entmer ortant injury		4 □ Donation 5 □ Other (Specify) 21. Signat e of Funeral Service License			emetery . Name and Add		007	Childs, N	
B	permi Depe Impo any it		I Donald &	Hickory	Hi 10	cks Hom 3 W. St	e for Fun ockton St	erals, P reet. El	.A. kton. Mary	7land 21921
X .			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	. Do not ente	er the mode of d	ying, such as cardia			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ACUTE RE	ENAL Jence of):	FAIL	UKZ			
e la	Examiner		Sequentially list conditions, b			PUCTION	√			
	rted nsit	mlnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):					
oʻ	be executed sician end burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
8760	physicist the bu	dlcal	d	•						
9 хо	death certificate be executed e attending physician end od for use as the burial-transit	n/Me	IF FEMALE; 23b. Was decedent pregnant	3c. If yes, outcome of pregnal		Ter			23d. Date of	delivery
P.O. B	at the death by the atte tached for	Physician/Medical	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnal Other (specify)			Month	Day Year
	gned gned	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause	given in Part I.			e to the cause of death? Probably 4 Donknown
ecords,	e law require has been si je 2 should b	Completed						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
$\mathbf{\alpha}$		Сош							ormed?// deat	h? Yes 2□ No
of Vital	Physician: The this certificate ral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	EP/Outpatier	nt 3 DOA		eath (Check only	one) idence 6 🗆 Other (S	Sanaki)
	Jing After fune	tlon: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. lr			how injury occurred	specify)
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify				28f. Location (City or To	(Street and Number own, State)	r Rural Route Number,
ت	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	(Check only 2 Medical Examin	sician: To the best of my kno- ner: On the basis of examinal						
	o the lithin 2.	Medi	29b. Signature and title of centile	and manner stated.		29c. Lice	ense number		29d. Date signed (N	
	⊢ s ⊢ ŏ		► \ \2000 \(\text{POUTO } \)				066348	6	March 22,	2007
	10		30. Name and address of person who co	, 106 BON	STREE	7.96	KTON, M	D 219	21	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 8 20	32 degistrar's Signa	iture	celle				

			State of Maryland / De State of Maryland / De Registrar #7, 3/19/07, per FHDR, H	epar KH	tment of He	ealth a Death	nd M	ental Hygi	ene 007	09783
	Dhusisi	0.00	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
н	Physici /Medio		Josephine Fuchs					3	10 07	2:00pM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		Death		4c. County of Dea	
I			Charlestown	7. 1	Catonsv		A Hrc	0.0	Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 1 M 2 1 F 7. Age (In yrs. last birth 94 97 97	rs.	Months Days	Hours	Min.	(Month, Day,	11719-09 5	thplace (State or Foreign puntry) [entina
-			Usual Residence of Decedent					11/13/1:	ALG	encina
	yland		10a. State 10b. County 10c. City, Town	or Loca	ation					10d. Inside City Limits
	Mai	iç	MD Howard Marr	iot	tsville					1 ☐ Yes 2 🙀 No
	th th	Director	10e. Street and Number		10f. Zip Code			10	g. Citizen of What Co	ountry?
	23a	a	2172 Sand Hill Rd.		21104				USA	
	de e	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cuban	spanic Orig	in? (Spec	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or if	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	10	☐Yes 2√2 No	Specify:			Specify.Whi	.te
Ş	filed within 72 hours after deeth with the Maryland Hygiene. other then "netural", or fleme 23s or 28e-f ehow ent, tra Medical Evatoliar must be notified at	be be		Decede	int's Usual Occupa	tion		1	6b. Kind of Business	Andustry
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7	with the second	E	Elementary/Secondary (0-12) College (1-4or 5+)	Seam	stress			I	Haas Tailo	ring
9	othe	Bec	17. Father's Name (First, Middle, Last)			18. Mother	's Name	(First, Middle, M		
<u> </u>	Menta Menta arked	ToE	Pietro Maenza			Mad	dale	na D'Ami	ico	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or iteme 23a or 28e-f ehow empty or other traumatic event, the Medical Examinat must be notified at Once.				Address (Street a				City or Town, State, . Llle, MD	Zip Code) 21104
ē,	thee item		20a. Method of Disposition 20b. Place of Disposition	Disposi	tion (Name of		Da	ate 2	0c. Location - City or	Town, State
e E	Pages ent of tr. If i		LYDURAL 2 LICHERIATION 3 LINERIOVALITORI STATE		itory or other place Iem. Park		15/2	007	Sykesville	, MD
Baltimore,	permit. Departm Importal eny inju		21. Signature of Euneral Service Licensee M01442	22.	Name and Address	s of Facility	Harr	y H. Wit	zke's FAm	ily FH Inc.
D_	8989		Mener L. Breden	41	12 Old C	olumb	ia P	k. Elli	Lcott City	, MD 21043
8/60,	Physician //Medical Examiner payarieu and physician and physician and the physician sit for the physician sit	dical Examiner	shock, or eart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of c. Due to (or as a consequence of d.	f): f):	emen ti	a				Interval Between Onset and Death
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year
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Division of Vital Records,	e law rec hes bee je 2 shot	Completed	Piabetes Mellitus	_				24a. Was an autopsy	24b. Were at prior to	utopsy findings available completion of cause of
<u> </u>	r. Th							perform 1 Tes 2		2 □ No
	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Other			Check only one		
ō	Phys rthis ral di	2	1 ☐ Yes 2 ☐ No		3L DOA	4PE IANI		le 5 ☐ Resider 8d. Describe hov	nce 6 Other (Spe	ocify)
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<u>s</u>	Attending Physicien: It death. ector: After this certifice by the funeral director.	flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	m, stree				8f. Location (Stre	eet and Number or R	ural Route Number,
5	s after si Dire	Certification:	4 Homicide determined building, etc. (Specify)					City or Town,	State)	
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificete hy completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death o	occurred at the time estigation, in my op	e, date and inion, deat	place, a h occurre	nd due to the car d at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License	number		29	d. Date signed (Mon	th, Day, Year)
			Kleasen Berlin, mp		044	377			3/12/07	}-
5	00 a		30. Name and address of person who completed cause of death (Item 23a) (T	-	rint)				The mo	
ř	Sta	te.	31. Date filed (Month, Day, Year) 32. Refistrar's Signature	N C	hoice L	-cerce	,	insvi	IILE MIS	1
	Registr		31. Date filed (Month, Day, Year) MAR 1 3 2007 32. Registrar's Signature	4	and!					

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			For State of Ma State of Ma Registrar	ryland / Depa <i>Cel</i>	artment of He rtificate of D		, ,	giene Reg. No 2	007	09784
ngiệc C	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al .	Ruth Virginia Finnerty 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death	March		007 ounty of Death	7:35 P
<i>)</i>	Examin	C!	Berlin Nursing & Rehabilitat	ion Ctr.	Berlin			Wo	orceste	r
	Funeral Director		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Nov. 2	h	9. Birth	place (State or Foreign ntry) D
	and w		Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Lo	cation					10d. Inside City Limits
	Maryli -f sho iied al	tor	DE Sussex	Selbyvi	lle					1 ☐ Yes 2 No
	th the	Director	10e. Street and Number	0010,711	10f. Zip Code			10g. Citize	n of What Cou	ntry?
	ath wii 23a ust b	ral	38898 Seagull Rd.		19975			USA		
36	be filed within 72 hours after death with the Maryland Hylgiene. d other than "natural", or Items 23a or 28a-f show dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Φivorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ XN: If Yes, Give Year or Dates:	0	Was Decedent of Hisp If Yes, specify Cuban 1 ☐ Yes 2☐ No		ecity Yes or No- Rican, etc.)		Black, White, pecify: White	, etc.
Maryland 21215-0036	72 hou natura dical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of work	ing I	16b. Kind	of Business/Ir	ndustry
121	within "ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+	-)	no not use retired) ice Manage			Dai	ilroad	
2	filed v Hygic other i	Be Co	17. Father's Name (First, Middle, Last)	011		: r 18. Mother's Nam	e (First, Middle,			
/lan		To B	William C. Shipley			Ruth Go	ough			
lar)	au is		19a. Informant's Name/Relationship (Type. Print)	1	ng Address (Street an					ip Code)
e,		- 1	Ada May Shipley 20a. Method of Disposition		Seagull sition (Name of matory or other place)		Date Date		199/5 ation - City or T	own, State
Jou	Pages nent of int: If its iry or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place, lopen Crem			Fran	ıkford,	DF
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee		2. Name and Address		Burbag			
8	8 3 5 6		full L. Smil		08 William				811	
	Physician	9	23a Part1. Enter the seas complications that caused shock, or heart failure at only one cause of each line immediate Cause (Findisease or condition a.	hewww.		, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
4	/Medical Examiner		resulting in death) Due to (or as a	consequence of):						
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68760,	be exician a		Due to (or as a	consequence of);						
687	£	edical	d					-		
ŏ		an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		Ectopic pregnancy			23	d. Date of deliv	•
O. B	The law requires that the death cer ale has been signed by the attendin page 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)				Month	Day Year
Δ.	res that the de signed by the a be detached	/ Ph	Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause giver	n în Part I.	23e. Did t	obacco use	contribute to	the cause of death?
rds	w requires been sign should be	ed by					1 🗆 '	∕es 2□	No 3□ Pro	obably 4 Unknown
Records,	ne law re has bee ye 2 sho	Completed					24a. Was	an	24b. Were aut	opsy findings available ompletion of cause of
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Vital	sician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes Hospital: 1 Inpatier	nt 2 ☐ ER/Outpatier	Othor	26. Place of Deal				***
0	g Phy er this eral di	n: To	27. Manner of Death 28a. Date of Injury	y 28b. Time o		at	ome 5 Residence 128d. Describe I			ity)
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	To the within 2 To the comple	Med	one) and manner state 29b. Signature and title of certifier	ied.	29c. License	number		29d. Date	signed (Month	, Day, Year)
)	- 5 m O		H Well	D	Da	8769		3/	126	7
,	anin		30. Name and address of person who completed cause of de	eath (Item 23a) (Type	Print)	<i>!</i> ,	Ī.	1.	TI	Pe, 2944
	BAIZ		31. Date filed (Month, Day, Year) 82. Bogistra	r's Signature	Courted W	reguiry	rena	rest_	Lough	De 1 chad
	Sta Registr		MAD 1 3 2007	# A	porte	4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U / Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year March 10, 2007 5:57^{p M} Fazio Vincent 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Bethesda Suburban Hospital
5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs.

Wonths Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 → M 2 □ F Yrs Dec. 14, 1927 New York 79 129-20-4668 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 13103 Ideal Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Special ite WWII 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Systems Analyst Computer Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Ferraro Joseph Fazio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13103 Ideal Drive, Silver Spring, MD 20906 Gloria Fazio/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition March 15, 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Address Con Vins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 5 ENGO 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Months disease or condition resulting in death) Metastatic Colon Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 2 No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 √ do 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? ∕es 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes XXNo 1 X Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be

Physician /Medical Examiner Examiner burial-tran

Physician

/Medical

Director

Funeral

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be martified.

Maryland 21215-0036

Baltimore,

physician s the burial Physician/Medical attending ph for use as tl <u>۾</u> Completed page 2 s certificate director, Be မှ Medical Certification:

d in by the

that the death certificate be executed P.0. Records, Vital 0 Division

Hospital or Attending nacent thin 24 hours aft the Funeral Di mpletely filled in within 7

Registrar

(30. Name and address of person who comple John J. Merendino,	
Sta	31. Date filed (Month, Day, Year) MAR 1 3 2007	9

29b. Signature and title of pertition

4 ☐ Homicide

29a. Certifier

determined

1	\sim	1/1	
ple	ted cause	of death (Item	23a) (Type, F
,	M.D	10215	Fernwo
_	3 Re	gistrar's Signa	ture 🥒

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D36046

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29d. Date signed (Month, Day, Year) March 11, 2007 March 11,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ood Road, #405, Bethesda, MD 20817

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10,2007 **Physician** MARCH 1:35 P DOUGLAS GREGORY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign NEW YORK 8. Date of Birth Month, Day, Year) 10-31-1959 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ØCIM 2□F Director 47 219-76**-**7051 Usual Residence of Decedent filed within 72 hours after death with the Marylend permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any Injury or other fraumatic avent, the Wadical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Funeral Director SILVER SPRING MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 U.S.A. 1111 UNIVERSITY BLVD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1X Yes 2 □ No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify: BT.ACK 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12th POSTAL WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DOUGLAS W. GREGORY LUEIVE GREGORY DENNIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOUGLAS W. GREGORY/FATHER 2041 QUAIL CIRCLE CREEDMOOR, NC 27522 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD VETERANS CEMETERY 20a. Method of Disposition

Y□ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 3-16-2007 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER R DLANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner HEPATITIS C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit **PANCREATITIS** and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicien Certification; To Be Completed by Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death sate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? (es 2 No 1 🗆 Yes 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√ No Marient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) D58376 3/13/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RACHEL VILE, MD 1500 FOREST GLEN RD SILVER SPRING, MD 20910 31. Date filed (Month 5 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2007 MARCH 4:58A GRIFFIN LUCILLE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 🗗 F 88 1918 MARYLAND 577-24-0583 MAY 4 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show r 28a-f show notified at 1X Yes 2 No Director PRINCE GEORGE'S CHAPEL OAKS MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be U.S.A. 20785 5001 LERAY GORHAM ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 No Specify: Specify: 2 3 HWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) PRIVATE College (1-4or 5+) marked other than Elementary/Secondary (0-12) FOOD SERVICE 6th ر مراجعة المصرد , مروه 1 and 2 should be file Department of Health and Mental Hys, 'mportant: If item 27 is marker' by injury or other ? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THOMAS CARRIE FRANK THOMAS ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9918 GREEN SPIRE WAY BOWIE, MARYLAND 20721 19a. Informant's Name/Relationship (Type. Print) SYLVIA SAMPLETON/NIECE permit. Pages 1 a
Department of Hee
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND RESURRECTION CEMETERY 3/9/2007 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Censee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYE CODONAY SYNDROME /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Ents Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by DISEATE 1 Tyes 2 No 3 Probably 4 Unknown CODONARY ARTERY 24b. Were autopsy findings available prior to completion of cause of HRONIC OBSTRUCTIVE 24a. Was an DULMONAY has autonsy page 2 death? 1 ☐ Yes 2 ☐ No performe 2 No certificate 1□ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 AR/Outpatient 3 DOA 1 Tes 2 Volvo 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 5 Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death.

To the Funeral Director: completely filled in by the f

death certificate be executed P.O. Box 68760 The law requires that the Division or Vital Records, Hospital or Attending Physician:

within 72 hours after

filed

Maryland 21215-0036

Baltimore,

6 Could not be determined 3 ☐ Suicide 4 Homicide

29a. Certifier

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D50689

29d. Date signed (Month, Day, Year) 03 03

30. Name and address of person who completed ause of death (Item 23a) (Type, Print) ANILE MANASANTO SOUTHERN MANYLOND HOSMEN CENTER 7503 SURRATTE RD

20731 CLINTUNMO

31. Date filed (Month, Day, Year, MAR 1 5 2007

32. Registrar's Signature

State Registrar

To the

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9, 2007 Physician March 8:15 George, Sr. L. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's 7410 Wilhelm Drive Lanham If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9-6-1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1XM 2□ F Director 579-32-0907 80 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. Slate 10d. Inside City Limits •how item 27 le marked other then "neturel", or items 23a or 28s-f ebov other treumatic event, the Medical Exercitar coust be notified at 1 X Yes 2 ☐ No MD Prince George's Lanham Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7410 Wilhelm Drive 20706 death v United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Deceden! Ever in U.S. Armed Forces? 11. Marital Status e filed within 72 hours after al Hygiene." neturel', or Ite MYes 2 □ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Completed by Specify: Black 3 Widowed 4 □ Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Systems Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 and 2 should be finent of Health and Mental It and It tem 27 le marked of Harry Anderson Mary Davis 19a. Informani's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaMon A. George (SON) 7410 Wilhelm Drive Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Pege Department of Important: If eny Injury or once. Fort Lincoln Cemetery 3/16/2007 Brentwood, MD 21. Signalure of Funeral Service ticensee 22. Name and Address of Facility Fort Lincoln Funeral Home Brentwood, MD 20722 3401 Bladensburg Road how -23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer of Pancreas, Metastatic 3 months **Physician** disease or condition resulling in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physicien for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy performed? 1 Yes 2 💢 No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2 ER/Outpatient 3□ DOA this 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident Injury 5 Pending 1 Tes 2 No 24 hours after death. Funerel Director: A investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) and title of certify DC 13778 3/14/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2100 Pennsylvania Ave. NW Washington, DC 20037 Thomas Tesoriero, MD 32. Registrar's Signa 31. Date filed (Month, Day, State MAR 1 5 2007 Registrar

				for State AMEND#9,pe:	State of I rFH,3/14/07,D			artment of F		nd M		giene Reg. No.	0.0	7	09789
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				Usual Residence of Decedent				l	1 1	1	200. 1		713	1101	. 10111 010)
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	eath	ns 23	Funeral	6121 Montrose R	oad 12. Was Decede	ent Ever in U.S.	13 \	208		n? (Sne	city Yes or No		14. Race -		ean Indian
	e fer o	r-lten	Fun	1 Never Married 2 Marri	Armed Force od 1 ZYes 2	s? □No Army	7	Was Decedent of H f Yes, specify Cubi		Puerto	Rican, etc.)			White,	etc.
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	S S	Hygie other ant, II		17. Father's Name (First, Middle, L	.ast)			ouncerman	7	s Name	(First, Middle,		staur Sumame)	ant	
	<u>a</u>	ked c	To Be	David Green					Fann	nie	Charne	У			
	ary shou	s mar	-	19a. Informant's Name/Relationsh	ip (Type, Print)	- 4	19b. Mailir	g Address (Street			·		r Town, St	ate, Zip	Code)
	and 2	n 27 i		Dr. David Green	n - Son		800 1	Montgome	ry Lane	, S	uite M	50, 1	Bethe	sda	, Md. 20814
	ore les 1	of He item		20a. Method of Disposition 1 A Burial 2 Cremation	3 □Removal from Sta	cem	etery, cren	sition (Name of natory or other place	ce)		ate		cation - Ci	-	
	E g	lant:		`4 □Donation 5 □ Other (Sp		Gard		f Remembi		-	/2007			_	, Maryland
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinational Demolities at once.		21. Signature of Funeral Service L	Stattle	mu	£ 10	Name and Addre dward Sag 091 Rocky	ss of Facility ge1 Fur ville F	nera Pike	l Dire	ction ville	n, In e, Ma	c. ryla	and 20852
				23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused by one cause on each	sed the leath.	Do not ent	er the mode of dyir	ng, such <i>a</i> s ca	ırdiac o	r respiratory a	rrest,			Approximate Interval Between
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CK.), execu	n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequer	ice of):						·	-	
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5		as th	Aedi	(FEFENALE)	1	-							-		-
Q'	S ta	attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth	me of pregnancy		Ectopic pregnancy	/			2	23d. Date o		•
X	О. Вефе	the at hed fo	sici	1 Pes 2 No 9 Unknown	4□Pregnant 9□Unknowr	t at time of deat n	h 5□	Other (specify)					Month	1	Day Year
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5	Records, P.O. Box 6 The law requires that the death certifit	been signed by the should be detached	ed by								10	_	1	□ Prob	
	Division of Vital Record	5 5	Completed								24a. Was		24b. We	re auto	psy findings available inpletion of cause of
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,	of Vita Physicien:	© :E	은	1 ☐ Yes 2 No	Hospital: 1 Inpa		/Outpatien				ne 5 Resid				1)
	On G	n. After funer	lon	27. Manner of Death Natural 5 Pending		Day Year)	Bb. Time of Injury	Wor	yat k? Yes 2 ⊡No		28d. Describe I	now injur	y occurred		
	ISIC Ittend	death. ctor: A y the fu	licat	Accident investig	ot be	Injury - At home	farm str	eet, factory, office	163 2 140		28f. Location (Street and	d Number	or Rura	I Route Number,
	Div	after Dire	Certification:	4 Homicide determine	building,	etc. (Specify)	, 101111, 011	soi, factory, office			City or Tov	vn, State)		
	Division To the Hospital or Attending	within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be examiner: On the basis	s of examination	dge, death	occurred at the tir	me, date and popinion, death	place, a	and due to the ed at the time,	cause(s) date and	and mann place, and	er as st	ated. the cause(s)
	o the	o the	Mec	29b. Signature and title of certifier	and manner	SIATEU.		29c. Licens	e number	-		29d. Date	e signed (/	Month,	Day, Year)
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9	Physic	ion	1. Decedent's Name (First, Middle, Last)				2 Date of Death	h	3. Time of Death
	Physic /Medi		Rosa Flor Guzma					March	Day // ZDC	7 8:40 m
<i>]</i> 	Examii	ner	4a. Facility Name (If not institution, give Bellimore Wash. 5. Social Security Number 6. Se	Medical C	enter	blent	SUME		Anne Al	rundel
п	Funeral Director				s. last birthday, 95 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Nov . 11,	1911 Pe	rthplace (State or Foreign Country) LU
	D		Usual Residence of Decedent 10a, State 10b, County	140-5						
	e Maryla Sa-f shov	ctor	Maryland Prince Ge		city, Town or Li verdale					10d. Inside City Limits 1X Yes 2 □ No
	th with th 23a or 21	Funeral Director	10e. Street and Number 5400 Patterson Roa	ad		10f. Zip Code 2073	7		og. Citizen of What C Peru	country?
36	e filed within 72 hours after death with the Maryland at Hygiene. other than "naturel", or Items 23a or 28a-f show vent, the Medical Examinat must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ Nó If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub	dispanic Origin? (Si an, Mexican, Puerto Specify: Pe	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
215-0036	thin 72 hou e. en "nature Medicel E	Completed by	15. Decedent's Edu (Specify only highest gradi	cation	(Give	DO NOT use retire	pation during most of work	1	6b. Kind of Business	s/Industry
7 0	filed w Hygien Sther th	S	17. Father's Name (First, Middle, Last)		nomen	laker	19 Mothode Nom	o (First Middle 14	own hor	ne
yland	ould be Mental narked o	To Be	Juan		Chavez		Hilaria	e (First, Middle, M		Ibanes
, Mar	and 2 sh salth and n 27 is rr		19a. Informant's Name/Relationship (Ty Milagros Hernandez		19b. Mailii ter 540	ng Address (Street 00 Patter	and Number or Rui son Road	al Route Number, Riverdale	city or Town, State, e, Marylan	zip Code) nd 20737
saitimore,	nit. Pages 1 and artment of Healt ortant: If Item 2 injury or other 1		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		cametary crei	esition (Name of matory or other place leaven Cet	ra) i		oc. Location - City of Silver Spi	r Town, State ring, Marylan
Dall	permit. Page Department all Important: If ony injury or once.		21. Signature of Funeral Service Licens	10 mm	Î	Name and Addre	Bor ward	t Funera	1 Home, PA	A 10070F
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	LOV	th. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arres	viiie, Mai st,	Approximate Interval Between Onset and Death
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.O.	To the hospital or Attending Physician: The law requires that the death certification 24 hours after descretations and the control of the Funeral Director After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
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j i	ng Ph	on: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	. 30 000	4 Nuising No	28d. Describe how		cny)
	Attending to death.	Certification:	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, stre	M 1	Yes 2 □ No	28f. Location (Stre	et and Number or Ri	ural Route Number
5	to the Hospital or Atlanding Physician: The within 24 Hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		4 D Homodo	building, etc. (Special	fy) 			City or Town,	State)	
:	ne Fun 124 ho ne Fun vietely	edicai	(Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	ation and/or inv	estigation, in my op	ne, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	s stated. e to the cause(s)
-	within To the comp	Me	29b. Signature and title of certifier	Alle n	^ ·)	29c. License	6536	29d	J. Date signed (Mont	h, Day, Year)
	'		30. Name and address of person who cor JAYASHREE AMISC		n 23a) (Туре, 1	Print) Wash	inglan	Hush f.	301	Hospital
Ď,	Sta		31. Date filed (Month, Day, Year)	32 A egistrar's Signa			1	1 - pera	There	M.)

			State State	of Maryland / [-			ental Hygie	ne		
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate	or Deatr		Reg	No.	17	3. Time of Death
	Physici							Month	Day	Year	
A.	/Medic Examir		Emmy Heumann Gutzeit 4a. Facility Name (If not institution, give street and	number)	4b. City, T	own, or Location		March 14	4c. County of	of Death	9:10 A M
1	Exami	*	745 Lingan Lane			Owings				Calv	ert
4	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	Months		er 24 Hrs.	3. Date of Birth (Month, Day, Y			lace (State or Foreign
tack:	Director		220-36-8440	77	Yrs.	Days Hours			1929	_	rmany
	and t		Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	or Location					1	0d. Inside City Limits
	Maryl f sho	to	MD Calvert County	Owin	œ						1 □Yes 2M No
	r 28a	Director	10e. Street and Number	7 Owing	10f. Zip (Code		10g	. Citizen of W	hat Coun	itry?
	th with		745 Lingan Lane			20736			U.S.	Λ	
	ems er mu	Funeral	11. Marital Status 12. Was D	ecedent Ever in U.S. Forces?		ent of Hispanic O fy Cuban, Mexica	Origin? (Spec	ify Yes or No-	14. Race		an Indian,
36	s after		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes	es 27 No Give X	1 ☐ Yes 2			, 0.01)	Specify:		
Ö	hours tural' al Ex	ed by	3 ☐ Widowed 4 ☐ Divorced Year of Year	r Dates:	Decedent's Usual	Occupation		16		AATIT	
7	in 72 " na" na Medic	olete	(Specify only highest grade complete	ed)	(Give kind of work life. DO NOT use	done during mo retired)	ost of working	7	b. Kind of Bus	siriess/iric	lustry
212	d with giene r tha the N	Completed	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	Homemake	er			Home		
b	al Hyellor	BeC	17. Father's Name (First, Middle, Last)			18. Moth	her's Name (First, Middle, Ma		9)	
ylaı	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show armatic event, the Medical Examiner must be notified at	10	Edward Heumann			Th	iersa I	Windschul	h		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street and Numi	ber or Rural	Route Number, C	ity or Town, S	State, Zip	Code)
e,	1 and Healt em 2	1	Lothar Gutzeit (Husba	nd) 74:	Lingan Disposition (Name y, crematory or oth	Lane, C	wings.	Maryla	nd 207	36	wn State
no.	ages int of t: If it		1 ☐ Burial 2 XI Cremation 3 ☐ Removal fro	JIII State		ner place)		-,			•
altimore,	nit. Partme ortan injur		4 □ Donation 5 □ Other (Specify) 21. Signature of English Nice □ Spee	Liee Ci	rematory 22. Name and	Address of Faci	200 T ee T	Funeral 1	linton	, Mai	ryland rt DA
ä	Dep Imp any		MANUEL N. ASSE		8125 Sc	outhern	Maryla	and Blvd	. Owi	ngs.	MD 20736
	16 18 18 18 18 18 18 18 18 18 18 18 18 18		23a. Part1. Enter the disease or complications the	at caused the death. Do n						Ť	Approximate Interval Between
14	Physician		Immediate Cause (Final disease or condition	pertension	3~						Onset and Death
	/Medical Examiner		resulting in death)	to (or as a consequence of		9					
(1)	LAdillilei	<u>_</u>	Sequentially list conditions, b.	perlipide	ma						
	ted nsit	Examiner	Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury	obacio A	buse						
	execunary and al-tra	Exar	that initiated events	to (or as a consequence of			_			-	
8760,	certificate be executed iding physician and ise as the burial-transit	dical	dO	steoporos	ال						
9	rtifical ng phy as th	l edi	IF FEMALE	· · · · · · · · · · · · · · · · · · ·							
Box	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, 1□Liv	outcome pf pregnancy re birth 2 Fetal death	3 □Ectopic pre	gnancy			23d. Date		•
0	at the death by the atter stached for u	Physician/Me	1 Ves 2 Via 4 Pr	egnant at time of death iknown	5 ☐ Other (spe				Mon	tri	Day Year
۵.	that thed by detac		Part II. Other significant conditions contributing to	o death but not resulting in	the underlying cau	use given in Part	ı.	23e. Did tohac	co use contril	hute to th	e cause of death?
Records,	The law requires that ste has been signed by bage 2 should be deta	d by		•	, , , ,	3					ably 4 □Unknown
Ö	w requir been si should	ete						24a. Was an	24h W	loro autor	osy findings available
	sician: The law certificate has birector, page 2 s	Completed	-					autopsy performed	1? pi	rior to cor	npletion of cause of
Vital		Be C	25. Was case referred to medical			26. Plac	ce of Death (1 Yes 2 Check only one)	HNo 1	□Yes	2 □ No
or <	Physical this ce all direct	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1	☐ Inpatient 2 ☐ ER/Out	patient 3 DOA	Other		e 5 AResidenc	e 6 □Othe	r (Specify	()
_ _	fter mera	:uo	27. Manner of Death 1 Natural 5 □ Pending (N	te of Injury 28b. T Ionth, Day Year) Ir	ijury	c. Injury at Work?		d. Describe how	njury occurre	d	
<u>S</u>	Attendi death. cctor: A y the fu	cati	2 Accident investigation		M	1 ☐ Yes 2 ☐				_	
Division	I or Attend after death. I Director: /	Certification:	determined 200. Fig	ace of injury - At home, far ilding, etc. (Specify)	m, street, factory,	office	28	f. Location (Stree City or Town, S	t and Numbe Itate)	r or Rura	l Route Number,
	spita nours neral y fillec		29a. Certifier 1 Certifying Physician: To	the best of my knowledge,	death occurred a	t the time, date a	and place, an	nd due to the caus	e(s) and mar	ner as st	ated.
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	edical	(Check only 2 Medical Examiner: On the one)	anner stated.							
	With With Elon	Σ	29b. Signature and title of certifier	1	29c.	License number		29d.	Date signed	(Month, I	Day, Year)
			- Alle Vlee	fe MD	D	5214:	7	In	auch	14	,2007
	10		30. Name and address of person who completed o	Hospital	Type, Print) S	LUTE:	310	PFrodo	SILL	Un	20670
	Sta	te		. Registra s Signature	icus U	-0	- 10	111000		1040	-0010
	Registr		MAR 1 6 200	1) Beens s	B AD04	(E)					

Kenneth Cleopes Glasco 07-01694 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2007 09792 1. For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Month Day March 3, 2007 Medical Examiner Year 1050 hrs Kenneth Glasco 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4716 John St Suitland Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Country) Washington Months Director Davs Hours Min 577-44-4896 70 1X M 12/24/1936 2 F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 Yes 2 No Prince Georges Suitland after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4716 John Street 20746 USA Funeral 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Armed Forces? White, etc 1 X Never Married Married Itimore, MD 21215-0036

it. Pages I and 2 should be filed within 72 hours after de urtment of Health and Mental Hygiene.

retant: If item 77 is marked other than "natural", or in y or other traumatic event, the Medical Examiner muy Ves Specify: Black If Yes, Give Year Unk 1 Yes 2 No specify. 3 Widowed 4 Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Disabled Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Cleopas Glasco Mildred Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore, MD Glasco - Nephew Aladdin 103 North Hamilton Street # I Richmond VA 23221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Department or Important: 1 injury or oth Metropolitan Crematory 3/14/2007 Alexandria VA Donation 5 Donation Specify 22. Name and Address of Facility Pope Funeral Home Bal 5538 Marlboro Pike Forestville Maryland 20747 I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one car se in each line Between Onset and Madical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final dis-ase Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and s the burial - trans sician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the ned by the attending detached for use as t 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed by 2 should be detach Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene After this 1 🗸 Yes ဥ 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 28b. Time of Injury Certification 1 V Natural 1 Yes 2 No 5 Pending death. within 24 hours after death To the Funeral Director: the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29th Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

ORIGINAL

March 4, 2007

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signatu

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

State

Williams

Margarita Korell MD.

			1 - For State Registrer	7				t of H	ealth a		lental Hyg	jiene eg. No.		7	097	93
	13		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	th Day	,	Year	3. Time of	Death
	Physici /Medio		Marion Pratt Ghe	elmini							March 8	3, 2	007		5:45	РМ
	Examir		4a. Facility Name (If not institution, given	e street and number	er)		4b. City,	Town, or	Location of	of Death		4c.	County	of Death		
			Anne Arundel Med:	ical Cent	er			apol					nne			
	Funeral		,	Sex 7. 1 □ M 2		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 7-31-1	Year)			place (State ontry)	
14.14	Director		100 20 2333	-X	96	Yrs.					7-31-1	910		Con	nectic	ut
	and and		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	ty, Town or Lo	ocation								10d. Inside C	ity Limits
	de h	ō	Maryland Anne A	runde1		Edgev	vater								1 🗆 Yes	2 📉 No
	288-	rect	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of V	hat Cou	ntry?	
	3a or	Completed by Funeral Director	409 Fairlea Driv	2			21	.037					US	SA		
	199ath	era	11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	T	14. Race	- Amer	can Indian,	
<u>.</u>		교	1 Never Married 2 Married	Armed Force						1, Puerto	mican, etc.)			k, White		
Ö	Per.	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date	s;		1 ☐ Yes	ZM NO	Specify:				Specify	: W1	nite	
21215-0036	netu netu	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usua kind of woi	l Occupa	ation during mos	t of work	ing	16b. Ki	ind of Bu	siness/l	ndustry	
7	9 e 4	npie	Elementary/Secondary (0-12)	College (1-4	or 5+)	_	kind of wor DO NOT us)							
7	tied within 72 hours after death with the Maryland Hygiene, then "neturel", or iteme 23a or 28a-f ehow ent, the Maulcal Examine must on notified a	Š	12th			Sec	retary	7	40 Marka	Nin-n	· /First Middle				overnme	ent
ב י	tal H d otl	To Be	17. Father's Name (First, Middle, Las	"					18. Mothe		(First, Middle,	walden	Sumam	Θ)		
<u> </u>	Men Marke Marke	ျ	Morris Pratt				-	15.			Lalley	0.11	-	O	0.41	
Maryland	permit. Pages 1 and 2 should be tited within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. eny injury or other traumatic event, the Marylaal Examinat mant be notified at ance.		19a. Informant's Name/Relationship Joanne B. Haines				-				a <i>l Route Numb</i> e. ewater,				p Code)	
6	Health Health H 27 Hert			ritend	20h F						Date				own, State	
Baltimore,	r if its		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [II B	Place of Dispo cemetery, cre					1					
E E	tant:		4 □Donation 5 □ Other (Special		St	. Mary				3-12			apo]			
3a	Depar Depar Impor ony in		21. Signature of Funeral Syrics Lice	nsee		2	2. Name an	d Addres	ss of Facilit	y Ge	orge P.	Kal	as I	une	ral Hor	ne
_	402 e d		larm f auc		4.45		-	-			nd Rd. I		walt	:1, 1	Approxima	
a ç			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on eac	h line.	\circ		1		cardiac	or respiratory an	rest,			Interval Be Onset and	tween
	hysician		Immediate Cause (Final disease or condition resulting in death)	_ a		ma	range	اد د	`						19	4
	/Medical Examiner		Toolanny in county	Due to (or	as a consec	quence of):									,	/
		e	Sequentially list conditions,	b. Due to for	as a cons ».	wence of										
	ed sit	oju	Sequentially list conditions, by lacong minimacile cause. Enter Underlying Cause (Disease or injury that initiated events	Duo to for	as a conse,	derice of .										
	and al-tra	Examin	that initiated events resulting in death) Last	c. Due to (or	as a consec	quence of):	_									
760,	te be executed ysicien and le burial-transit	calE														
				d												
×	The Taw requires that the death certificate be executed ble has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcome									23d. Dat	e of deli	/erv	
Вох	atter	clar	in the past 12 months?	1⊡Live birth 4⊡Pregnan			□Ectopic pr □ Other (sp						Mo		,	Year
о. О.	y the	yst	1 □ Yes 2 Ū⁄32 9 □ Unknown	9 Unknow	n											
σ.	that ned b	y P	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	ındəriying c	ause givi	en in Part I		23e. Did to	bacco i	use conti	ribute to	the cause of	death?
sp.	urres sign	d by			_						1 □ Y	es 2	₽No	3 🗆 Pro	bably 4 🗆	Unknown
Records,	w requires to been signer should be	Completed									24a. Was :	an	24b. \	Vere au	opsy findings	available
Re	sician: The law certificete has b irector, page 2 s	E E									autop	med?	(death?	ompletion of	cause of
	ifficet or, pe		25. Was case referred to medical						26 Place	a of Deat	1 ☐ Yes h (Check onl) o	1		☐ Yes	2□ No	
5	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2] ER/Outpatie	nt 3 DC	Oth	00		me 5 Resid		6 ∏Oth	er (Spec	ify)	
ō	g Phys er this eral di		27. Manner of Death	28a. Date of	Injury	28b. Time o		Bc. Injun	y at		28d. Describe h			1-1		
<u>.</u>	Attending F r death. ector: After by the funera	aţio	Natural 5 Pending 2 Accident Investigation		Day Year)	Injury	М	Worl	Yes 2 🗌	No						
Division	Attendi r death. ector: A by the fu	100	3 Suicide 6 Could not determined	4 Z00. FIZUO UI	Injury - At h	nome, farm, st	reet, factory	, office			28f. Location (S City or Tow			er or Ru	ral Route Nur	n <i>ber</i> ,
á	a afte	Medical Certification:	4 [] Homicide	building	, etc. (Speci	ny)					City of You	III, State	9)			
	spita nours nere	a	29a. Certifier 1 Certifying P	hysicien: To the b	est of my kn	owledge, dea	th occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s) and ma	nner as	stated.	
	ne Ho	dic	(Check only 2 Medical Exa	miner: On the basi and manner		ation and/or in	nvestigation	, in my o	pinion, dea	ath occur	red at the time, o	date and	d place,	and due	to the cause(s)
	To the Hospital or Atlending Physician: The within 24 Hours after death. To the Funerel Director: After this certificete h completely filled in by the funeral director, page	ž	29b. Signature and title of certifie		~				e number	· f					, Day, Year)	
			14/2	win)			03	TER	6		5/	18/	71	/	
			30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type	, Print)	()		7 4	4					
-	0		Vay J (M	we o	4108	17 170	nut-	120	ve (سلاه	he, M.)	911	619	9	
(T)	Sta	ate	31. Date filed (Month, Day, Year)	2007 32 Aeg	istrar's Sign	ature										

			1 - For State Registrar	State of Maryla	•	artment of Health and tificate of Death	мептат ну	rgiene	09794
	Dhyoisi		Decedent's Name (First, Middle,	Last)			2. Date of De Month		3. Time of Death
	Physici /Medio		VIVIAN	LORETTA	GALE		3 -	- 9 - 200	7 4:05 AM
	Examir	er	4e. Fecility Name (If not institution,	1 - /		4b. City, Town, or Location of Dea	ith	4c. County of De	
	Foreset		22369 Rot		a. last birthday)	If Under 1 Year If Under 24 Hrs	s. 8. Date of Bi	th 9. Bi	
	Funeral Director		218-24-5806 Usual Residence of Decedent	1□M 28€ 78	Yrs.	Months Days Hours Min	. (Month, Da	7-1928 M	rthplece (State or Foreign ountry)
	yland how		10a. State 10b. County		ity, Town or Lo	cation			10d. Inside City Limits
	Ba-f e	ctor		mieo C	JUANT:	Co			1 ☐ Yes 2 No
	th with the	Funeral Director	10e. Street and Number 22369 Roys	al Cak Roa	d	10f. Zip Code 21856		10g. Citizen of What C	country?
	tama ter m	unei	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Vas Decedent of Hispanic Origin? (I Yes, specify Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	o- 14. Race - Am Black, Wh	
9003	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itama 23a or 28a-f ehow event, The Medical Exameler must be notified at	ē	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		☐ Yes 2 No Specify:		Specify:	olack
7	in 72 i	Completed	15. Decedent's (Specify only highest	grade completed)	16a. Deced (Give	lent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking	16b. Kind of Busines:	s/Industry
212	d with piene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	I	omestic		None	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itama 23a or 28a-f ehow any injury or other traumatic event, the Medical Examination at once.	To Be C	17. Father's Name (First, Middle, La		Priable		4.0	, Maiden Sumame)	
ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street and Number or R			Zip Code)
	and selth m 27 m 27 her tr		GERALdINE GO	laman Daughte	n 223	69 Koun Oak	Kond 6	chanties, M	21856
Baltimore,	Pages 1 nent of H int: If ite ury or ot		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Chambrai ilom State	cemetery, cren	N (EMETERU 3	Date 17-2007	20c. Location - City o	Town, State
3alti	permit. Departn Imports any inju	Ī	21. Signature of Funeral Service Li	censee		. Name and Address of acility	C. 1	1010	11 401
	Q □ E e o		Blady B.	Slewarf	5		me 8211	WEST (G), 5	Alls. 1 d 21801
			23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final	1,	ath. Do not ente	or the mode of dying, such as cardia	c or respiratory a	irrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse		c Cancer			2ms
7	Examiner		Conventially list conditions	b	400.100 0.7.				
	sit sit	Examiner	Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ur as a conse	cuance ofly				
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68760,	ificate be executed g physician and as the burial-transit	edical E		d.					
	rtifical ng ph) as th	Medi	IE ECMALE.					10.00	1
Вох	ath ce ttendii or use	lan/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	aldeath 3	Ectopic pregnancy		23d. Date of de Month	blivery Day Year
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ري ص	The law requires that the death centificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant condition	s contributing to death but not re	sulting in the ur	derlying cause given in Part I.	23e. Did 1	tobacco use contribute t	o the cause of death?
ğ	equire en sig ould b						1 🗆	Yes 2 <mark>2⊒N</mark> o 3⊟F	robably 4 Unknown
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o	g Phy er this	\vdash	27. Manner of Death	28a. Date of Injury	28b. Time of	3 DOA 4 Nursing I 28c. Injury at Work?		dence 6 Other (Spe how injury occurred	ecify)
io	ttending F death. ctor: After y the funera	atlo	1 Accident 5 Pending investigat		Injury	Work? M 1 □ Yes 2 □ No			
Division of Vital Records,	al or Attended after death	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		nome, farm, stre	et, factory, office	28f. Location (City or To	Street and Number or F wn, State)	lural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time, date and placestigation, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Si para and title of a rtifier	/1		29c. License number		29d. Date signed (Mon	th, Day, Year)
	00		* Low !	CKA		HOUT6197		3/12/2017	
1	0 92		30. Name and address of person when 2 1 ?	so completed cause of death (Ite	m 23a) (Type, I	29c. License number #0056197 Print) MS 21801		7/1 (1)	to full and
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1012 2100)		-	Vir
35	Registr		MAR 12	2007	K 1	call 1			
DHN	MH 17 Rev 1/20	001		F-CASUR-1	n. The				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical or Location of Death 4c. County of Death Facility stitution Examiner 009 WICOM 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Director 135-24-5926 75 6-2-1931 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a, State show 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6242 Oxbridge Dr. 21801 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔀 No Specify. Specify. 3 Widowed 4 Divorced ear or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Financial Controller Factory Pages 1 and 2 should be filed went of Health and Mental Hygis ant; If Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan gitin ပ Lillian Seidel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria B. Gitin - wife 6242 Oxbridge Dr., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If Ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) \$pringhill Memory Gds. 3-17-07 Hebron, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Furieral Service Ligensee 705 E. Main Street, Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, france, leading to infined a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) as the burialthe attending physician the for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 M No 3 Probably 4 Unknown has e 2 page this certificate Certification: To Be After thi

P.O. Box 68760, Division or Vital Records, or Attending Physician: within 24 hours anen com.

To the Funeral Director: Aftremately filled in by the fur To the Hospital

Baltimore, Maryland 21215-0036

		24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of Death Check onl one
1 Yes Sy No	Hospital: 1 → npatient 2 □ ER/Outpatient 3 □ DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of eath Natural 5 Pending Accident investigation	ion (Month, Day Year) Injury M	Injury at Work? 28d. Describe how injury occurred Work?
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ice 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 29a. Certifying 1 2 Medical Ex	Physician: To the best of my knowledge, death occurred at the aminer: On the basis of examination and/or investigation, in a and manner stated.	ne time, date and place, and due to the cause(s) and manner as stated. my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Medical

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

2000			For State Registrar	State of M	laryland /		artment of H rtificate of I			giene Reg. No.		09796
	Physici	an	1. Decedent's Name (First, Middle, I	EARI	G	0 =	ER		2. Date of De Month	ath Day		3. Time of Death
	/Media	al_	4a. Facility Name (If not institution, g		,	7-	4b. City, Town, or	Location of De	MAR	10	County of Dea	-
	Examir	ier	Howard County Ge				Columbia	Location of De	balli		ward	2011
	Funeral				ge (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 F Hours M	Irs. 8. Date of Bir	th	9 Bi	rthplace (State or Foreign
	Director		072-14-0000	1124M 2∐F	83	Yrs.	Months Days	Hours M	May 21	192	3 Ne	w York
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	ocation					10d. Inside City Limits
	Maryl -f sho iled a	to	Maryland Howard		Columb	ia						1 ☐ Yes 2 Z No
	or 28a	irec	10e. Street and Number		0020112		10f. Zip Code			10g. Citi	zen of What C	ountry?
	within 72 hours after death with the Manyland ene. than "hatural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	6336 Cedar Lane	#309			21044			USA		
	er dez Items ner m	nue	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	-	14. Race - Am Black, Whi	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Mayes 2 ☐ If Yes, Give Year or Dates:	No 1943–46		1 □ Yes 2 🛣 No	Specify:			Specify: Wh	
9	2 hou atura cal E	ted	15. Decedent's	 Education		a. Dece	dent's Usual Occupa	ation			nd of Business	
215	thin 7 e. an "n Medi	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or	5+)	(Give life.	kind of work done o DO NOT use retired	luring most of v)	working			,
21	filed wi Hygien other the	Con		1	Ac	cour	it Execut:			L	lity Co	ompany
and	l be fil ntal H ed oth	Be	17. Father's Name (<i>First, Middl</i> e, <i>La.</i> Nelson Torrance	,					Name (First, Middle, Ruby Mc1		Surname)	
Ž	d 2 should be filed within 72 hours after death with the Manylan Ih and Mental Hygiental Hygiental Hygiental Hygient Than arked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	으	19a. Informant's Name/Relationship		19	h Mailir	ng Address (Street a				r Tawa State	Zin Cada)
Ma	nd 2 salth ar 27 is rtrau		John N. Greer/so	n	6	121	Fence Pos	st Cour	t Columbi	.a, M	D 2104	4
Baltimore, Maryland 21215-0036	Pages 1 and 2 ment of Health ant: If item 27 ury or other tra		20a. Method of Disposition		oomot	of Dispo	sition (Name of matory or other place	a)	Date	20c. Lo	cation - City or	Town, State
<u>E</u>	Page ment ant: If ury o		1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				ce Cremato		/13/07	Be1t	sville	, MD
3alt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic	ensed //		G	Name and Addres	s of Facility Cremat	ion Servi	.ce	P.O. Bo	ox 784
	<u></u>	/i !	Devely I	Heritte	MO125	$1 \mid B\epsilon$	everly L.	Heckro	tte, P.A.	C1a		le, MD 21029
	8	3	23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final	y one cause on each	ine.			g, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	SEPTI		SHOCK					1 DAY
	Examiner				a consequence		ACT 1	FECT	10N			1 DAY
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Box (leath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy					2	3d. Date of de	livon
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S,	res t igne be d	by	Part II. Other significant conditions	contributing to death b	out not resulting	in the ur	nderlying cause give	n in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?
or Vital Records,	w require been sig should b	Completed							- 1 - 1 - 1	/es 2	¶No 3∏P	robably 4 □Unknown
ဒ္ဌင	The law te has b	nple							24a. Was autop	sy	prior to	utopsy findings available completion of cause of
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Ħ.	Physiclan: this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	0.D.ED/O		t 3DDOA Othe		eath (Check only o			
0	g Phy er this eral d	٦. ا	27. Manner of Death	28a. Date of Inju		Time of	· oll box	4 Li Nursing	Home 5 ☐ Resid			ecify)
Ö	Attending r death. ector: After by the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da on	y Year)	Injury		? ′es 2 □ No				
	or After der director in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	 Zoe. Place of inj 	ury - At home, fac. (Specify)	arm, str	eet, factory, office		28f. Location (S City or Tox			ural Route Number,
Ω	urs aff urs aff aral Di											
:	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	thysician: To the best nminer: On the basis o and manner st	it examination a	e, death nd/or inv	n occurred at the tim vestigation, in my op	e, date and pla inion, death oc	ace, and due to the courred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	To the P	Mec	29b. Signature and title of certifier	and manner su	ateu.		29c. License	number		29d. Date	e signed (Mont	th, Dav. Year)
	>=0		MBm.D	mi lon	Δ		Doo	6256			10,	
140) a3	-	30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, I	Print)					•
<u>ت</u>			M. Brad Drummons	10724	Little F	Pato.	Print) Xent Pkw	1 Colo	mbia, MI	> :	21044	
	Sta Registra		31. Date filed (Month, Day, Year) MAR 1 4	32. degistr	ars Signature	A						

			For State Registrar		partment of Health and Nertificate of Death	Mental Hygiene Reg. No	2007 1979
	Physici		1. Decedent's Name (First, Middle, Last	YN VINSO	N HOLMES	2. Date of Death Month De	y Year 3. Time of Death 78 2007 1600 M
<i>f</i> :	/Medic Examin		4a. Facility Name (If not institution, give	/	4b. City, Town, or Location of Death		County of Deeth
	Funeral Director		5. Social Security Number 6. Se 2 2 3 - 78 - 4442	7. Age (In yrs. last birthda M 2 7 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year,	9. Birthplace (State or Foreign Country) VIRO-INIA
	show	2	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or	APeke		10d. Inside City Limits 1. ✓ es 2 □ No
	with the M a or 28a-f be notified	Director	10e. Street and Number	NS CREEK R	101 7 0 1	10g. Ci	itizen of What Country?
36	72 hours after deeth with the Maryland natural; or tems 23a or 28a-1 show ilsal Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Servorced		3. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	within Bne. than	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation 16a. De (G (G (ift) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of work by DO NOT use retired Lege	king	FD4CATION
Maryland 2	uld be filed fental Hygi rked other tic svent, L	To Be C	17. Father's Name (First, Middle, Last) WALTER L.	VINSON SR		RL BA	own
	and 2 should alth and Mer 27 is marke sr trsumatic		19a. Informant's Name/Relationship (T	OlMES - DAughter	alling Address (Street and Number or Ru 921 MAHNS Cree		or Town, State, Zip Code) es VA 23320
Baltimore,	Pages 1 an ment of Heal ant: If item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State		16/07 C	ocation - City or Town, State hes APEKE UA
Balt	permit. I Departm Importal any inju		21. Signature of Funeral Service License Koffun / Mul	son	22. Name and Address of Facility M		NORFOIK UA 2352
	Physician Medical Physician and Physicia	Examiner	shock, mean filter. List only of the condition of the condition resulting in death)	ne cause on each line.	enter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
P.O. Box 68760	death certifi e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	law requires thet the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions co	ntributing to death but not resulting in the	e underlying cause given in Part I.		use contribute to the cause of death?
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Divis	i i i te	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical			eath occurred at the time, date and place r investigation, in my opinion, death occu		
	Vith To t	Σ	29b. Signature and title of certifier	10 +	29c. License number		ate signed (Month, Day, Year)
,		1	20. Name and address of person who o	ompleted cause of death (Item 23a) (Typ	17005577	Ma	nck 15, 2007
	10		Solvador Syl	vs Tv Do 300/	oe. Print) Hospital Dri-	re Chare	by Hayland
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 2 8 2007	32. Registrar's Signature	de la	,	-/

D. Box 68760,
9.
Records,
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of
Division

		For 1 State	Type or Print in B State of Maryland	lack Indelible Ink. I / Department of H Certificate of I	lealth and M	lental Hygi	ené () () 7	09798
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Examir Funeral Director	ner	S. Social Security Number 6. S 577-10-0616	SHINGTON MEDI	CAL CTR GLE	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1 12/26/1	ANNE Year) 9. Bi	ARUNDEL thplace (State or Foreign ountry) irginia
tiled within 72 hours after deeth with the Maryland Hygiene. Hygiene. Whysiene.	Usual Residence of Decedent 10a. State 10b. County	10c. City	. Town or Location				10d. Inside City Limits 11∑Yes 2☐No	
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with t	5	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?
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after dee or iteme	Ξ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 23 No	If Yes, specify Cuba	ın, Mexican, Puerto	Rican, etc.)	Black, Wh	te, etc.
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thealth Health Hem 27 other tr		20a. Method of Disposition	20b. Pla	ace of Disposition (Name of metery, crematory or other place	! [Oc. Location - City o	r Town, State
00		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		. Lincoln Cemet		0/2007 E	rentwood,	, MD
그 등원수		21. Signature of Funeral Service Licer		22. Name and Addre	ss of Facility \overline{F} t.	Lincoln		Home, Inc.
Permi Popara		Words Montagn	ens. Chatran	3401 Blade	ensburg Ro	oad Bren	itwood, MI	20722
Physician		23a. Part 1. Et er the disease of com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	Do not enter the mode of dyin		or respiratory arres	st,	Approximate Interval Between Onset and Death
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	i.i	27. Manner of Death 1 KNatural 5 ☐ Pending	28a. Mate of Injury (Month, Day Year)	28b. Time of Injury Wor		28d. Describe how	v injury occurred	
tendi feath for: /	cat	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □ No			
or All	Certification;	4 ☐ Homicide determined	building, etc. (Specify,	ne, farm, street, factory, office		City or Town,	eet and Number or F State)	tural Houte Number,
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun		29a. Certifier Certifying Pr	ysician: To the best of my know	yledge, death occurred at the tir	ne date and place	and due to the car	ISA(S) and manner of	s stated
Hos 24 h Fur etely	edical	(Check only 2 Medical Examone)	niner: On the basis of examinati and manner stated.	on and/or investigation, in my o	pinion, death occurr	ed at the time, dat	e and place, and du	e to the cause(s)
To the Mithin Fo the	Me	29b. Signature and title of certifier	. 0 4 . 11	29c. Licens	e number	29	d. Date signed (Mor	th, Day, Year)
		> same	a jum M	000	06183	2 /	MARCH	12 2007
(12)		30. Name and address of person who	T 1 11				21061	
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	# 27	Jan Dul	,		
Regist	rar	MAR 1 5 2007	32. Registrar's Signat	of the				

		1 - For State Registrar	State of M	laryland	-	artmen rtificat			and M		Reg.	2111	7	097	99
Physici /Medic		Decedent's Name (First, Middle, La Mary Margaret								2. Date of D Month March		Day 2007	Year	3. Time of 6:20	
Examir		4a. Facility Name (If not institution, giv Friends House)		4b. City,		Location o				4c. County	of Death	ery	
. Funeral Director		5. Social Security Number 6. S 579-44-6419 Usual Residence of Decedent	Sex 7. And 1	ge (In yrs. las 98	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, E August	Day, Ye		9. Birthp Cour	olace (State o htry) Ohi	
the Maryland 28e-f show officed at	Director	10a. State 10b. County Maryland Montgon 10e. Street and Number	nery	10c. City, 7	Town or Lo	Sandy		ıg			100	Ciaires of h		0d. Inside Ci	٠.
in 72 hours after death with the Maryland "natural", or Items 23c or 28e-1 show calcal Examinat must be notified at	by Funeral	17340 Quaker La 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 15. Decedent's E. (Specify only highest gra	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	t Ever in U.S. ? No	16a. Deced	1 🗆 Yes	20 dent of His cify Cubar 2 ▼ No	Specify:		ecify Yes or N Rican, etc.)	10-	14. Rac	S.A. e - Americ k, White,	ean Indian, etc.	
filed withlr Hygiene. ther than	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last,	College (1-4or	5+)		oo not us at ist i	ician			e (First, Middl		America den Sumam		Cross	
permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic avonce.	ToB	Martin Loftus 19a. Informant's Name/Relationship (Carolyn H. Prentice 20a. Method of Disposition 1	- Daughter Removal from State (y)	20b. Plac	1475 se of Disponetery, crent Lincol	Old An sition (Name natory or o	nnapol ne of other place natory	is Roa	ad, We	eth Clem al Route Num boodbine, Date 2007	MD 200	ty or Town,	City or To	own, State	
death certificate be executed Way Way Way Way Way Way Way Wa	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Oue to (or as c.	s a consequer	Ince of):	hni ona	ne ry Imi	fai	1	er.	. /	ge de	adin.	Approximatinterval Bet Onset and I	tweer
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ine iaw requires ate has been sign page 2 should be	Completed by		The state of the s	J	g ni tro Ul	.acriying 6				24a. Wa auto per 1 Yes	Yes s an opsy formed 2 D	2 100 24b. V	3 Prob	ably 4 L psy findings inpletion of ca	Unkr
After this (ertification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner		ury 28 ay Year)	VOutpatien Bb. Time of Injury	M 2	8c. Injury Work 1 🗆 Y	^C 4 \ \ \ 4 \ \ \	rsing Hor	me 5 ☐ Res 28d. Describe	sidence how in	njury occurr	ed		
Funerel Dir	edical Certifi	4 Homicide determined 29a. Certifier 1 Certifying Ph	289. Place of In	tc. (Specify) of my knowle	dge, death	occurred	at the time	e, date and inion, deat	d place, a	28f. Location City or To	own, Si	(a te)	nner as si	ated.	
within 2 To the complet	Med	29b. Signature and title of certifier	and mainer si	a.		290	. License	number			29d.	Date signed	(Menth,	Day, Year)	

			1 - For Amend #20b F State Registrar 1. Decedent's Name (First, Middle, Li		\$Marylan	d/d ^{Pep}	rtment o	f Hea of De	ith and ath	$\overline{}$	ntal Hyg		2007	3. Time of Death
	Physici		DOROTHY K. HARAB	231)							Month MARCH	Day		
7	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and nu	mber)		4b. City, Tow	n, or Loc	ation of Dea		ARCH		County of Death	3:37 P [™]
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	Funeral Director		,	Sex 1 □ M 2 🔼 F	7. Age (In yrs.	last birthday) 7 Yrs.	If Under 1 Y Months Da		Under 24 Hr ours Mir		Date of Birth	1919		lace (State or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
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	r 28a- notif	Director	10e. Street and Number				10f. Zip Co					10g. Citiz	zen of What Cour	ntry?
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0	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he M. cical Examiner must be notified at	Funeral	11. Marital Status 1	12. Was Dec	edent Ever in U. orces? 2 X 7 No		Was Decedent If Yes, specify			(Specif erto Ric	fy Yes or No- can, etc.)		14. Race - Americ Black, White,	etc.
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פב	should be filed within 72 hou and Mental Hygiene. s marked other than "natura iumatic event, the M. cical E.	Be	17. Father's Name (First, Middle, Las	t)						,	First, Middle,	Maiden	Surname)	
Maryland	d Men narke	10	MICHAEL KLEIN	(Time Dried)		10h Mailia	an Address (CA		ETTA			0:1:	r Town, State, Zip	0.41
Z	id 2 sh th and th and traur		19a. Informant's Name/Relationship ELLIOT PETER HARA				-						MARYLAN	*
ē,	s 1 ar if Hea item 2	3	20a. Method of Disposition		20b. F		sition (Name o			Dat			cation - City or To	
Ē	Page Int: If		Burial 2 □ Cremation 3 (4 □ Bonation 5 □ Other (Spec		State NA	TIONAL	CAPITO	LCem	0.03/1	1/2	007	CAP	ITOL HEI	GHTS, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic es		21. Signatur a of Funeral Sausce Lice	ense <i>e</i>	,	E	2. Name and A DWARD S	AGEL	FUNE	RAL	DIREC	TIO	N, INC. E. MARYL	AND 20852
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	Physician	i	Immediate Cause (Final disease or condition		ROVASCU								1	Onset and Death
1	/Medical Examiner		resulting in death)		(or as a conseq		OLDENI							
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20 20	The law requires that the death certific te has been signed by the attending proage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	come pf pregna pirth 2 ☐ Feta	Ideath 3	Ectopic pregn					2	23d. Date of delive Month	ery Day Year
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7	w requires that the deben signed by that should be detached		Part II. Other significant conditions	contributing to d	eath but not res	ulting in the u	nderlying caus	given in	Part I.		23e. Did to	bacco u	se contribute to t	ne cause of death?
Records,	quire; en sign	Completed by	CONGESTIVE HEART	FAILURE						- (1 □ Y	'es 2[□ No 3 □ Prot	ably 4 \ Unknown
D D D	faw re as bee 2 sho	plet									24a. Was a		24b. Were auto	psy findings available mpletion of cause of
Ē		E O									perfor	med? 2 X No	death?	
VITal	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?	Hospital:							Check only o			
0	this h	- To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o		Injuny at	1 ☐ Nursing		5 X Resid		3 □Other (Special	y)
0	ding th. : Afte	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Mon	th, Day Year)	Injury		Injury at Work? 1 ☐ Yes	2 □ No		a. Describe ii	ow mjur	y occurred	
UIVISION	ppital or Attending Physours after death. Interpreter: After this filled in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	20e. Place	of injury - At heing, etc. (Specif	ome, farm, str	eet, factory, of	fice		281	f. Location (S City or Tow	treet and n, State	d Number or Rura)	al Route Number,
	ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After to oletely filled in by the funera	Medical C		iminer: On the b									and manner as s i place, and due t	
	To the Hosp within 24 ho To the Fund completely f	Me	29b. Signature and title of certifier	and man	s.atou.		29c. Lie	ense nu	mber		2	29d. Dat	e signed (Month,	Day, Year)
•	F>F0		Dalen B.	Hollis	L m	D		D284	26		:	MAR	RCH 9, 20	007
•	26		30. Name and address of person who	0			Print)							
	23	Y. U	DR. GALEN B. HALL				ROAD, S	UITE	100,	BE	THESDA	, MA	RYLAND	20817
	Sta Registr		31. Date filed (Month, Day, Year)	2007 32.	gistrar's Signa	ature								

State of Maryland / Department of Health and Mental Hygiene amdnded#10f, 1- State F.D., TCHD, 3/14/07, sbb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 10 PAUL E. HIGGINS 2007 7:50AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL MANOR EASTON TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1**X**M 2□F Hours Yrs 89 Director 224-09-3357 JAN 14, 1918 WEST VIRGINIA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28e-f ahow the Medical Examiner must be notified at Director 1X Yes 2 □ No MD TALBOT ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21663 213 MARENGO ST. IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: ð Specify: 3 X Widowed 4 ☐ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 CONTRACT MANAGER MANUFACTURING other traumatic event, 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mental int: If item 27 is marked o WILLIAM HIGGINS ADA BLAKELY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA M. HIGGINS/DAUGHTER 28171 OAKLANDS ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State = 5 Department Important: If any injury or soce. ' 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 3/12/2007 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCEROF JOHN K. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final DUZGI 9 days Physician 0 disease or condition resulting in death) /Medical Due to (or as a cons eau ince (f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its agents.) Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events iding physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Huknown signed by Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 DUnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes /2 No 2 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide • Funeral (the Hospitel 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. WOOD, JR. M.D., 501 DUTCHMANS LANE, EASTON, MARYLAND 21601 gistrar's Signature State Registrar

Registrar

SAUSBURY MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

106

MUFORD ST.

distrar's Signature

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ORIGINAL

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		,	For State	State of Ma	aryland / [/lental Hy	-	000	0000	TAN .
	_		Registrar 1. Decedent's Name (First, Middle, La	et)		Cei	rtificate of	Death	2. Date of De	Reg. No	2007	3. Time of Death	C
	Physicia /Medic		Ronald	Rohm	Hixon				Month 03	Da 15	y Year 07		М
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of Death		40	. County of Dea	th	
	Funeral Director	-,	5. Social Security Number 6. S	Hospital ex 7. Age V∏M 2□F	e (In yrs. last bir 66		Cumber If Under 1 Year Months Days		8. Date of Bi (Month, Di	ay, Year,	0	tħplace <i>(St</i> ate o <i>r For</i> e o <i>untry)</i>	ign
	O		215-36-7116 Usual Residence of Decedent						reducity	01,1	.7+1 [<i>E</i>		
	arylar show	ŗ	10a. State 10b. County		10c. City, Tow							10d. Inside City Lim 1 ☐ Yes 2 💢 I	
	the M 28a-f notifie	rect	PA Fulton		Warfor	dsb	urg 10f. Zip Code			10g. Ci	tizen of What C		
	h with 23a or st be	Funeral Director	1152 Lehman Road				17267			US	SA		
	r deat tems 2	ner	11. Marital Status	12. Was Decedent I Armed Forces?		13. 1	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No Rican, etc.)		14. Race - Ame Black, Whi		
20	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Healt and Mental Hygiene. I of Health and Mental Hygiene. I of Health and Mental Hygiene. I or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2			1 □ Yes 2X No	Specify:			Cif	nite	
5	2 hou latura ical E		15. Decedent's E (Specify only highest gra	ducation		Dece	dent's Usual Occup	ation	kina	16b. k	ind of Business		
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0	should be ind Mental i marked o imatic eve	To Be	Grant Hixon					Carolyn	Smith				
	2 shou and N Is ma		19a. Informant's Name/Relationship (Type. Print)	19b	. Mailir	ng Address (Street	and Number or Ru	ral Route Numi	ber, City	or Town, State,	Zip Code)	
ב ע	Health Health tem 27 I		Patricia A. Hixon 20a. Method of Disposition	/Wife	20b. Place o	52 f Dispo	Lehman Ro sition (Name of matory or other place	oad Warfo	rdsburg		17267 ocation - City or	Town, State	
2	ages ent of tt: If Its y or o		1 Burial 2 □Cremation 3 □ 4 □Donation 5 □ Other (Specia				natory or other plac Chriatian	03/1	7/07		•	,	
<u> </u>	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra		21. Signature of Funeral Service Cice	**	puck vai		2. Name and Addre				ordsbur Main St	0,	
۵	e a m m e		Kuclen	2 Miles	Ca				,P.A. H	lanco		1750-0368	
	F + 3		23a. Part1. Enter the disease, or con- shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ne.				or respiratory	arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	eATOR:	of):	FAILU	<u>K</u> E				6 DAYS	
	Examiner		Sequentially list conditions.	b. CHEON	KOBS	TR	UCTIVE	PULMO	NARY	214	ENSE	YEARS	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):			· ·			′	
Ć,	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	cDue to (or as	a consequence	of):							
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2	sw red	Completed							24a. Wa			utopsy findings availa	
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2 2	ician: sertifica ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea	th (Check only	one)			
5	tending Physician: The lavelauth: tor: After this certificate has the funeral director, page 2:	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ry 28b.	tpatier Time o	nt 3 DOA Oth f 28c. Injui Wor	4 LI Nursing H	ome 5 ☐ Res 28d. Describe		6 □Other (Sp	ecify)	
5	inding ath. rr: Afte	atior	Natural 5 ☐ Pending 2 ☐ Accident investigatio		y Year)	Injury		k? Yes 2 □ No					
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, fa c. <i>(Sp</i> ec <i>ify)</i>	ırm, str	eet, factory, office		28f. Location City or To	(Street a	nd Number or F e)	Rural Route Number,	
3	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier Certifying Pl	nysician: To the best	of my knowledge	e, deat	h occurred at the ti	me, date and place	, and due to the	e cause(s	s) and manner a	is stated.	
	he Hoo n 24 h he Fur pletely	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	f examination ar	nd/or in	vestigation, in my	opinion, death occu	rred at the time	e, date ar	nd place, and du	e to the cause(s)	
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)	Λ		30. Name and address of person, who	completed cause of d	eath (Itam 22a)	(Type	Print\	23 406		MA	PCH 1	1, 2007	-
	'\			imm 9a	O Seto	N N	DRIVE (Cumber	land,	mi	> 31.	5, 2007 502	
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			8500 CV F 10 -		- 4								

			For State Registrar			f Marylai	nd / Depa			ealth a D <i>eath</i>	and M	lental Hy	giene Reg. No:	007	09806
	nysicia		Decedent's Name (First JEAN McK)	, <i>Middle, L</i> ast) ELLAR	HOWEL	L						2. Date of D. Month March	eath Day 20	Year	3. Time of Death 6:20 P M
	Medic xamine		4a. Facility Name (If not in Wilson Heal	-		mber)		,		Location o			4c. Co	unty of Deat	h
	neral ector		5. Social Security Number 231-28-5383 Usual Residence of Deced	,	M 2[XF	7. Age (In yrs 92	. last birthday) Yrs.	If Under Months		If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, D Jan.	th ay, Yea <i>r)</i> 11,1915	9. Birt Co Bri	hplace (State or Foreign untry) .tish Columbi
death with the Maryland	ilistal	. [10a. State 10b.	County ntgomer	у		ity, Town or Lo								10d. fnside City Limits 1X Yes 2 □ No
with the	thenot	Direc	10e. Street and Number 415 Russell	Ave. #	802			10f. Zip	Code 208	377			10g. Citizen		,
2-UCSO 72 hours after death	1	ed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ Di	Married	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	2 X No '8 No	777.00	1 🗌 Yes	dent of Hi cify Cuba 2🏋 No	spanic Origin, Mexican		ecify Yes or N Rican, etc.)	o- 14.	Race - Ame Black, White	ncan Indian, e, etc. Thite
e filed within 72 at Hygiene.	The Medic	ompleted	(Specify only	highest grade	College (1	-4or 5+)	16a. Dece (Give life. Lab T				t of worki	ng			overnment
should be filed and Mental Hyg	tic event,	To Be C	17. Father's Name <i>(First, I</i> John H. McI									(First, Middle		name)	
permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is my	any Injury or other traum		19a. Informant's Name/Re Mary H. Ing1 20a. Method of Dispositior 1 Burial 2 Core 4 Donation 5 0	caham nation 3 🗆 R ther (Specify)	(Daugh	20b. State	101 E Place of Dispo commetery, cree tropoli	ast Sestion (Name and Control of	Sterl me of other place Crem.	ling I	Dr, Mar. 2007	12, 7 Vol Fur	ay, Ne 20c. Locati Alexa neral F	ew Jer on-City or andria Iome	Town, State
Physi	ician dical niner	Į.	23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	ſ	Due to	aused the dea ach line.	quence of):	er the mod	le of dying	g, such as	cardiac o	r respiratory a		,urg,	Md. 20877 Approximate Internal Between pet and Death
certificate be executed adding physicien and	e as the burial-transit	cal Ex	Securitally but condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		l	or as a conse			-						
the death ce	iched for us	Physician/Med	23b. Was decedent pregn in the past 12 month: 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ant	1□Live b	come of pregn irth 2 Pet ant at time of own	al death 3[Ectopic pr Other (sp					23d.	Date of deli Month	ivery Day Year
Cien: The law requires that the death sertificate has been signed by the atter	2 should be a	Completed by	Parl II. Other significant of Appendix Lemmas Teichure 25. Was case referred to	con to The	Rad	eath but not re phage iates	sulting in the u early encyc	nderlying c	ks	na h lesga hos	lege see	1 24a. Was auto perf	Yes 2 No	o 3 Pro	the cause of death? obably 4 Unknown topsy findings available completion of cause of
Attending Physicien: In death.	ineral di	9	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident	Pending investigation	-	npatient 2 [of Injury h, Day Year)	ER/Outpatier 28b. Time of Injury		8c. Injury Work	at	rsing Hor	Check only ne 5 Res 28d. Describe	idence 6		cify)
To the Hospital or Attendi Within 24 hours after death. To the Funerel Director: A	led in by t	Certification:	4 Homicide	Could not be determined	buildir	ng, etc. (Speci						City or To	wn, State)		ral Route Number,
To the Hoepital or within 24 hours after To the Funerel Dir	pletely fil	edical	29a. Certifier 1 DC (Check only 2 M one)	ertifying Phys adical Examin	sicien: To the ner: On the ba and mann	asis of examin	owledge, death ation and/or in	occurred vestigation	at the tim , in my op	e, date and pinion, deat	d place, a th occurre	and due to the ad at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
19 Similar 19	Cod	- 1	29b. Signature and title of		140	hles	andes		License .		5		29d. Date si		
1			VARALA 30. Name and address of A	RTS/				Print)	O1 eH1	740	ERS	BUR	E M	720	847
R	Stat egistra	e	31. Date filed (Month, Day MAR	1 3 200	7	egistrar's Sign	ature								

Division or Vital Records, P.O. Box 68760, Hospital or Attending 24 hours after death 9 Funeral Director: within 24 hor To the Fune completely f

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

29b. Signature and title of certifier

HULAM WAR 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00058410

29d. Date signed (Month, Day, Year)

RO BOX 1733 SALISBURY MD-21802

			1 - For State Registrar	Sta	ite of M	Maryland		artmen rtificat					giene Rog. No	7 El El	7	09308
	Physic	ian	Decedent's Name (First, Michael Control of the	idle, Last)							2	Date of Dea Month	ith Da	v \	'ear	3. Time of Death
	/Medi		JUANITA			JONES							11	2007		8:35 P M
	Examir	ner	4a. Facility Name (If not institut		and number	r)				Location of	of Death			. County of		
148	. 4	ě	9315 ALCONA 5. Social Security Number	6. Sex	7 A	ige (In yrs. last	t hirthday)	LAI If Under	1 Year	If Under	24 Hrs. g	. Date of Birtl	_			EORGE 'S
	Funeral Director		579-72-4092	1 M 2	Ø7 F	50	Yrs.	Months	Days	Hours	Min.	(Month, Day	r, Year)			place (State or Foreign htry)
	P _		Usual Residence of Decedent									EFI. I	0 1	930	200	TH CAROLINA
	ehow	_	10a. State 10b. Cour		r.i.o	10c. City, T		cation							1	Od. Inside City Limits
	72 hours after death with the Maryland naturel', or iteme 23a or 28e-1 ehow dical Examinar must be notified at	Director		E GEORG	E.2	LF	ANHAM	T								1 XYes 2 No
	with a or		10e. Street and Number					10f. Zip					-	izen of Wh	at Cour	ntry?
	leath	era	9315 ALCONA ST		s Deceden	t Ever in U.S.	13 \		706	enanic Ori	nin? (Specif	by Vas or No.		SA 14. Race -	Amaric	can Indian
(0	riter	Funeral	1 Never Married 2 1 M	Am	ned Forces	?	10.1	f Yes, spec	ofy Cuba	n, Mexican	, Puerto Rio	fy Yes or No- can, etc.)	1		White,	
03	rei', o	by	3 ☐ Widowed 4 ☐ Divorc	lf Y	es, Give 11 ar or Dates	•		∏ Yes 2	2 ∑ No	Specify:				Specify:	BL	ACK
21215-0036	n 72 hours after death with the Maryla *naturel; or Iteme 23a or 28e-f ehov golical Examinational be notified at	Completed	15. Deced (Specify only high	ent's Education	leted)	1	(Give	lent's Usua kind of wor	rk done d	u <i>rina</i> most	of working		16b. K	ind of Busi	ness/Ind	dustry
121	s within jiene.	mpi	Elementary/Secondary (0-12		llege (1-4or	5+)	life. I	DO NOT us	se retired,)						
2			12th 17. Father's Name (First, Middle	a last)			DIET	ARY C	OOK	19 Motho	do Nama //	Since Adjusted		PRIVA	TE	
Maryland	e d la b	Be c	RICKY NORR								OLA AE	First, Middle,	maiden	Sumame)		
Z	d 2 should be th and Mental 7 is marked o traumatic eve	2	19a. Informant's Name/Relatio		nt)		19b. Mailin	a Address	(Street a			Route Numbe	r City o	r Town St	ate Zin	Code
	ta ta		HARVEY JONES									IAM, MA				706
Baltimore,	一直宣言		20a. Method of Disposition			20b. Place	e of Dispo	sition (Nam	ne of		Date	9	20c. Lo	ocation - Ci	ty or To	wn, State
Ē	permit. Pages Depertment of I Important: If Its any Injury or o		1 Purial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		I from State	,					13-17-	2007	СТТ	NTON.	MD	
alti	Depenti Depenti Importa any Inju		21. Signature of Funeral Service	e Licensee	^ 1	TEBBOT		. Name and				B. JENI				HOME
	80 E 2 8		K.D.	M-h	all		7	474 I	LANDO	OVER		LANDOV				20706
			23a. Part1. Enter the disease, shock, or heart failure. L	or complications st only one caus	that cause e on each	d the death. [Do not ente	er the mode	e of dying	, such as	cardiac or re	espiratory arr	est,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	C C	omp	licat	ions	at	OL	nes,	ity					Onset and Death
4	/Medical Examiner		resulting in death)		ue to (or a	s a consequen	ce of):				1					
		-	Sequentially list conditions,	b	cia ka fas a	à donsaquein	es. one									
	nsit	Examine	Sequentially list conditions, if any, reading to infinitediate cause. Enter Underlying Cause (Disease or injury	≺	10 (0: a.	a consequent	Ge Oi).									
,	execun n and al-tra	Exai	that initiated events resulting in death) Last	c.	ue to (or as	a consequen	ce of):				_				-	
8760,	icate be executed physicien and s the burial-transit	dicai		d=												
9	# On es	ledi		- 0.												
Вох	death certific e attending p od for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If ye	es, outcome	of pregnancy 2 Petal dea		Ectopic pre	202004					23d. Date o	f delive	ry
	e dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4		t time of death		Other (spe						Month		Day Year
P.O.	d by t	Phy	9 Unknown													
Ś	The law requires that the death cer lite has been signed by the attendin bage 2 should be detached for use	þ	Part II. Other significant condi	hma	g to death i	out not resultin	ig in the un	derlying ca	ause give	n in Part I.	William Andreas					e cause of death?
Ö	w requir been s should	etec		1 Ma								1 U Ye	es 2[_No 3[Propa	ably 4X∭Unknown
Division of Vital Record	has l	Completed										24a. Was a autops	y	prio	r to con	osy findings available appletion of cause of
a			05.14									perform 1 Yes		dea 1 🗆	Yes	2 🛱 No
₹	Physiclen: this certificatal director, I	o Be	25. Was case referred to medic examiner? 1 ☑ Yes 2 ☐ No	Hospital								heck only on		_		
o	9 Phy er this	٦. آ	27. Manner of Death	28a.	1 ☐ Inpati Date of Inj	ury 281	Outpatient b. Time of		Bc. Injury Work	4 ∐ Nur at		5 Reside			Specify)
o	Attending ir death. ector: After by the fune	atio	1 X Natural 5 ☐ Pend 2 ☐ Accident inves	ling tigation	(Month, Da	y Year)	Injury	м		? es 2 □ N			•	,		
vis	i or Attending Phefor death. Director: After the in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Coull 4 ☐ Homicide deter	not be 28e.	Place of In	jury · At home, tc. (Specify)	, farm, stre	et, factory,	office		28f.	Location (St	reet an	d Number (or Rural	Route Number,
٥	rs eft el Di	Cer		19	ballaling, e	ic. (apecity)						City or Town	i, State,	,		
	Hospitel	edical	CHOCK ONLY ZIXI MIGUICI	ing Physician: I Examiner: On	To the best	of my knowled	dge, death	occurred a	t the time	e, date and	place, and	due to the ca	use(s)	and manne	er as sta	ated.
	To the Hospitel or Attenwithin 24 hours efter deat To the Funerel Director: completely filled in by the	Med		and	manner st	ated.										
1	Z 1 8 5	_	29b. Signature and title of certif	0 (/	10-	1.		29c.	License	number	-, -			e signed (A		
^		}	20 Name and address of	to /h	1	000	-) /=	N-1-12	NO	255	871	1	lac	el 1	4,	2007
2	7		30. Name and address of person SALVADOR SYLV					,	VF C	пелет	OTV N				-	
	Sta	te	31. Date filed (Month, Day, Yea	2	32. Regist	rar's Signat	TIL	ח אעד	VE U	III V E F	\ 1 .1	IAKILAN	עו	20785		
	Registr	ar	MAR 1 5 200	time	met 1	rar's Signatu				·						

			State of Maryland / Dep	partment of He		, ,		
			Registrar 1. Decedent's Name (First, Middle, Last)	Tillicate of L	- Calli	2. Date of Death	g. No. 200	3. Time of Death
	Physici		BERNICE E. JONES			Month MARCH 6	Day Yea	
1	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or I	Location of Death	MARCH 0	4c. County of D	
1			WASHINGTON ADVENTIST HOSPITAL	TAKOMA	PARK		MONT	GOMERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9.1	Birthplace (State or Foreign Country)
14%	Director		220-04-4333 1 M 2 F 78 Yrs.			OCT. 29	1928 JA	MAIĆA
	land ow t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits
	Mary -f sh fied a	ţō	MD PRINCE GEORGE'S BOWIE					1X Yes 2 □ No
	h the r 28a r noti	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of What	Country?
	th wit 23a o sst be		1203 GOLF COURSE DRIVE	207	21		USA	Δ
	hours after death with the Maryland tural", or Items 23a or 28a-f show at Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of His If Yes, specify Cubar		ecify Yes or No-		merican Indian,
36	s afte ; or it amin	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☑ No	Specify:	Though Stary	Specify:	
1215-0036	hour tural' al Ex	q pe	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	adant'a Hayal Occupa	tion			BLACK
Ċ	within 72 ene. than "na he Medic	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupat e kind of work done du DO NOT use retired)	urina most of work	ing	6b. Kind of Busine	ss/Industry
7.17	y with giene. r thai	mo.	Elementary/Secondary (0-12) College (1-4or 5+) COOK	,		ĺ,	PRIVATE	
٥	be filed within 72 hours after death with the Marylan ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Ma		
Maryland		P	VINCENT WALLEN		THERESA	WALTERS	STEWART	
<u>a</u>	s 1 and 2 should f Health and Mei tem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ling Address (Street ar	nd Number or Rur	al Route Number, (City or Town, State	e, Zip Code)
رة ج	s 1 and f Health item 27 other tr		SHERNET WILLIS/DAUGHTER 7902	BRAD COUR				
Ö	g = to		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, creations.	osition (Name of ematory or other place) [Date 20	Oc. Location - City	or Town, State
aitimor			4 □ Donation 5 □ Other (Specify) GATE OF					RING, MARYLAND
g	permit. Departr Importa any inju			22. Name and Address	. 0.	B. JENK		
100				7474 LANDO				AND 20785 Approximate
	Dhysisian		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ι Δ	, suom as cardiac	or respiratory arres	ι,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	17				-
	Examiner		CONGESTIV	E HEI	ART 1	FAIL	URE	
	7 +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	ecute ind trans	Examine	trial initiated events	ARRI	14 T H	MIA		
Ď,	be executed ician and burial-transit		Due to (or as a consequence of).	20/02 1	- A 11	110 =		
09/90	ficate be executed physician and s the burial-transit	dical	d. ACUIC KC	FNALI	FAIL	URE		
XOC	The law requires that the death certificate tee has been signed by the attending physioage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy				and Date of	1-11-
Ď	death a atter d for u	iciar	in the past 12 months?	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of o	Day Year
2	t the by the acher	hys	9 ☐ Unknown 9 ☐ Unknown	., ., ., .				
ν, T	ss tha gned l	by P	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given	n in Part I.	23e. Did toba	cco use contribute	to the cause of death?
cords,	equire en siç ould b	pa				1 ☐ Yes	2 □ No 3 □	Probably 4 XIUnknown
ວ ນ	law n as be 2 sh	Completed				24a. Was an autopsy	24b. Were	autopsy findings available
	The page	Con				performe	ed? death	
ק ק	iclan sertific ector,	Be	25. Was case referred to medical examiner?			(Check only one)		
5	Phys this al dir	P.	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatiel 27. Manner of Death 28a. Date of Injury 28b. Time of		4 Li Nursing Ho	me 5 Residence		pecify)
5	ding h. After fune	tion	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury	Work?	es 2 No	28d. Describe how	injury occurred	
	Atten deat ector;	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, str			28f. Location (Stree	et and Number or	Rural Route Number,
5	al or al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)			City or Town,	State)	Transfer Transport
	ospit hours uners		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or in	th occurred at the time	e, date and place,	and due to the cau	se(s) and manner	as stated.
	To the Hospital or Attending Physician: The law requiviting 45 hours attendenth. To the Funeral Director; After this certificate has been completely filled in by the funeral director, page 2 should	Medical	one) and manner stated.			ed at the time, date	e and place, and d	ue to the cause(s)
	Vith Con	2	29b. Signature and title of certifier	29c. License r			. Date signed (Mo	
Λ	(-	cuandiaraera Torps	1//	5285	> 5	- /- /	2007
1	-15/		30. Name and address of person who completed cause of death (Item 23a) (Type, CHANDRASEKHAR KORA	Print) OATI	7207	HANOY	IER P	KWY#B D-20770
	Sta	e		/	IKCC	NISCL	7. M.	U- 20770
	Registra	ar	31. Date filed (Month, Day, Year) MAR 1 5 2007 Seign S. Registrar's Signature A. April 1.	7				

			1 - For State Registrar	State of	Marylar		artmen <i>rtificat</i>				nental Hyg	gien Reg. N	THAC	09810
4	Physici	20	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	ath Da	ay Year	3. Time of Death
	/Medi			RDELL MAR		S						12	2007	4:04 A M
	Examir	ner	4a. Facility Name (If not institution,						Location	of Death		40	c. County of Deat	
	- Funda		NATIONAL NAVA			ER last birthday)	If Under	BETH]	ESDA If Under	24 Hrs.	8. Date of Birt	h	MONTGO 9 Birt	OMERY hplace (State or Foreign
	Funeral Director		579-48-0248	1□M 2√1F	74	Yrs.	Months	Days	Hours	Min.	04-25-1	932	WASI	HINGTON, DC
30	pu ,		Usual Residence of Decedent		10.0									1
	ehov ehov ed at	5	10a. State 10b. County MD PRINCE	CEODCE		ity, Town or Lo		^						10d. Inside City Limits 1 Yes 2 □ No
	the N	Director	10e. Street and Number	GEURGE	UP	PER MA	10f. Zip					10a C	itizen of What Co	
	3a or		34 BANNINGTON	DR								rog. o	U.S.A.	only:
	death	Funeral	11. Marital Status	12. Was Deced	lent Ever in U	J.S. 13.	Was Dece	774 dent of Hi	spanic Ori	igin? (Sp	ecify Yes or No-		14. Race - Ame	
9	or its	/Fu	1 Never Married 2 Marrie	Armed Ford d 1 ☐ Yes 2 If Yes, Give			n res, spe 1 □ Yes		n, mexicar Specify:	n, Puenc	Rican, etc.)		Black, Whit	
Š	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-1 ehow its Madical Examiter must be notified at	d by	3 XWidowed 4 □ Divorced	Year or Da	tes:			Λ					Specify: BL	
75	in 72	plete	15. Decedent's (Specify only highest	grade completed)		16a. Dece (Give life.	kind of wo DO NOT u	rk done d	furina mos	t of work			Kind of Business	Industry
212	d with giene.	Completed	Elementary/Secondary (0-12)	College (1- 5+	4or 5+)		EACHE				G	OVE	RNMENT	
Maryland 21215-0036	al Hyg	Bec	17. Father's Name (First, Middle, La								e (First, Middle,	Maidei	n Sumame)	
yla	Ment Ment arkec	To	RUSSELL HAMILTO						BERT	HA 1	UYREE			
Nar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Haalth and Mental Hygiene. Important: If item 27 le marked other than "natural", or items 23a or 28a-f show way injury or other traumatic event, the Manified Examiliat must be notified at once.		19a. Informant's Name/Relationship				-						or Town, State, 2	
e,	1 and Haaltl em 2 ther t		PENNY COLBERT/] 20a. Method of Disposition	DAUGHTER	20b. I	34 BA			DR U		MARLBO		MD 2077 ocation - City or	
no	ages int of t: If it	300	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from S	1010	cemetery, crei	natory`or o	ther place					NTWOOD,	
Baltimore,	nit. Partme ortan injur		21. Signature of Funeral Service Lie										NERAL IK	
ä	Depa Impo eny ir		D. H.	Lall		74	474 L	ANDO	VER R	D LA	NDOVER,	MD	20785	
**			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that canly one cause on ea	used the dear	th. Do not ent	er the mod	le of dying	g, such as	cardiac	or respiratory ar	rest,		Approximate fnterval Between
	Physician		Immediate Cause (Final disease or condition	s SI	MALL B	OWEL OI	STRU	CTIO	N					Onset and Death
	/Medical Examiner		resulting in death)		r as a consec									
		-	Sequentially list conditions,	b. One to fo	r as a consuc	tuacina off								
	uted 3 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
ó	axec an an	Exa	resulting in death) Last	Due to (o	r as a consec	quence of):								
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Medical	3	d.										
9	entific ling p	Med	IF FEMALE:	00 - 1/								T		
Вох	that the death certification bed by the attending properties of the control of th	lan/	23b. Was decedent pregnant in the past 12 months?		ome of pregnate th 2 □ Feta nt at time of c	al death 3	Ectopic pr						23d. Date of del Month	ivery Day Year
o.	the de y the iched	nysic	1 ☐ Yes 2 📆No 9 ☐ Unknown	9□ Unknov		19a(ii 5)_	J Other (Sp	өспу)						
S, P	es that igned b be deta	y Pl	Part II. Other significant conditions	s contributing to dea	th but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco	use contribute to	the cause of death?
ğ	w require been sig should b										1 🗆 Y	es 2	X No 3□Pr	obably 4 □Unknown
ecc	law re as be 2 sho	Completed									24a. Was a		24b. Were au	topsy findings available
<u> </u>		Com									perfor		death?	
/ita	Physician: this certificatal director, I	Be	25. Was case referred to medical examiner?	Unamitat						of Deat	h (Check only or			
Division of Vital Record	Physithis aldir	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospitaf:		ER/Outpatien			4 🗀 INU				6 □Other (Spec	cify)
O	ding h. After fune	tlon	1 XNatural 5 Pending 2 Accident investigat	(Month	Day Year)	28b. Time of Injury	M	8c. Injury Work	ai ? ′es 2 □ i	i	28d. Describe h	iow inju	iry occurred	
/IS	or Attending after death. Director: After in by the funer	ifica	3 Suicide 6 Could not	t be 28e. Place o	of Injury - At h	ome, farm, str								ıral Route Number,
	safter safter al Dire	Certification:	4 nomicide	building	g, etc. (Specil	ry)					City or Tow	n, Stati	9)	
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying	Physician: To the base	est of my kno	owledge, death	occurred	at the tim	e, date an	d place,	and due to the o	cause(s	and manner as	stated.
	To the P within 24 To the F complete	Medi	- O114)	and manne	r stated.									
	Cor T wit		29b. Signature and title of certifier	///	1	>		: License		(TN1		230. D8	ate signed (Monti	J. Day, Tear)
(i	(2)		3 Name and ddress of p son wh	no dimnfeted source	of death flin	n 23a) /Tuna		11024	801A	•		AT) / / / (CENTER
/			P.M	JK LCDR MO		25a) (1ype,	/				NAL NAV SDA MD			CENTER
	Sta		31. Date filed (Month, Day, 2007	32. Red	gistrar's Signa	opens.	j							
The same	Registr	ar 🔞	WHU TO FOOL	Lieury	1									

37-01923 George M. Johnso	Please Type or Print in Black Indelible		egible.
seorge IVI. Somiso	1- For State Certificate		2007 0001
Physician	Registrar	2. Date of D	
Medical Examine		Month March 1	1, 2007 Year 1519 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Calvert Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Prince Frederick If Under 1 Year If Under 24Hrs, 8. Date of	Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	217 60 7522 /0	Mantha Dava Haura Min	Foreign Country) MD
	Usual Residence of Decedent	Yrs. U5/1	9/1937 County PID
v any	10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
Aaryland 28a-f show Lat once.	MD Calvert S	underland	1 Yes 2 X No
tith the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 7515 Solomons Island Road	10f. Zip Code 20689	10g. Citizen of What Country? USA
vith th	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or	
r death with or items 23.	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
after or all', or iner n	3 Widowed 4 Divorced II Yes, Give Year 1	Yes 2 X No specify:	Specify: Black
hours	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	edent's Usual Occupation (Give kind of work done og most of working life. DO NOT use retired)	16b. Kind of Business/Industry
36 nin 72 E. than "	Elementary/Secondary (0-12) College (1-4 or 5+)	Laborer	Construction
5-00 ed with	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle	
121. I be fill ental H urked vent, t	Walter H. Johnson,	-carry - carry - aller	Jacks
Baltimore, MD 21215-0036 pemit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	19a. Informant's Name/Relationship (Type, Print) Catherine Johnson/mother P.0	Billing Address (Street and Number or Rural Route N $0.{ m Box}413$	Number, City or Town, State, Zip Code) and, MD 20689
e, M 1 and 2 Health item 2		sposition (Name of cemetery, Date	20c. Location - City or Town, State
mor Pages ent of nt: If	1 XBurial 2 Cremation 3 Removal from State E. JOI	or other place) nes Cemetery 3/19/07	Ches. Bch., MD
Baltii permit Departm Importa	21. Signature of Funeral Service Licensee 2	22. Name and Address of Facility Sewell	Funeral Home
	Slady G. Sewell 23a. Part I. Enter the disease, or complications that caused the death. Do not ent	1451 Dares Beach Roa Prince Frederick, MD	d ₂₀₆₇₈
Physician /Medial	failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory	arrest, shock, or heart Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Head Injuries Due to (or as a consequence of):		555
	Sequentially list conditions, b		
	if any, leading to immediate Due to (or as a consequence of):		
at q	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
executed ian and ial - transit	d. UNPENDED AMENDED		
50, te be e tysicia	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
587(rrtifica fing pl	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnancy	Month Day Year
Sox 68760, leath certificate be e attending physicia for use as the buria	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown Part II. Other significant conditions 2 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown	Other (Specify)	4
P.O. B res that the d signed by the be detached		he underlying cause given in Part I 23e. Di	d tobacco use contribute to the cause of death?
, P.O. res that th signed by be detach	Chronic Alcohol Abuse	1 🔲	Yes 2 No 3 Probably 4 Unknown
cords, taw requir has been s e 2 should b			topsy prior to completion of cause of
Reco			erformed? death? es 2 No 1 Yes 2 No
Vital Rec	25. Was case referred to medical	26 Place of Death (Check only one)	
Physic Price of this ral direction	1 Ves 2 No Impatient 2 ER/Outpat	tient 3 DOA 4 Nuising Home 3	Residence 6 Other:
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be ours after death. The law Director: After this certificate has been signed by the attending physic filled in by the funeral director, page 2 should be detached for use as the burgest of the control of	5 Pending FOUND: Day, Year) FOUND	1 Yes 2 ✓ No Subject fe	
ivisior or Attend after death Director:	2 Accident Investigation Mar 11, 2007 1450 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc. 28f. Locatio	n (Street and Number or Rural Route Number, City
Div	Suicide 6 Could not be determined (Specify) In car in driveway	or Town 7515 Solor	n, State) mons Island Road, Sunderland, MD
2 - 5 - 7		courred at the time, date and place, and due to the c	ause(s) and manner as stated
To th withir To th compl	(Check only one) 2 Medical Examiner: On the basis of examination and/or investant and manner stated 29b. Signature and title of certifier	29c. License number	29d Date signed (Month, Day, Year)
	William Browell 19th -	O.C.M.E.	March 12, 2007
	30. Name and address of person who completed cause of death (Item 23a)		
3	0	1 Penn Street, Baltimore, MD 21201	
Sta Registra		Solo	
A 1747 P-11	The state of the s	67	

Registrar

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Horiene	Important: If item 27 is marked other than "natural", or is any injury or other traumatic event. the Medical Examin	
	Phy /M Exa	sicia edic imin	
Division or Vital Records, P.O. Box 68760,	spital or Attending Physician: The law requires that the death certificate be executed ours after death.	neral Director: After this certificate has been signed by the attending physician and in filled in by the funeral director, page 2 should be detached for use as the burlal-transit	

		1- State of Marylar Registrar	nd / Department of Health and Certificate of Death	Mental Hygiene 2007	09812
Phys	ician dical	1. Decedent's Name (First, Middle, Last) HESTER EUZABETH SONES		2. Date of Death Month Day Year MANCH 2 2007	3. Time of Death
	niner	4a Facility Name (If not institution, give street and number) PENINSULA KECKIJAL MEDICAL CO	4b. City, Town, or Location of De		
Funer Directo	7.7	5. Social Security Number 6. Sex 1 M 2 K F 83		n. (Month, Day, Year) Cou	place (State or Foreign intry)
Maryland f show ied at	Tor.	n-	ity, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 🖔 No
3a or 28a- st be notif	Funeral Director	10e. Street and Number 20777 MFD CARF LANE	10f. Zip Code	10g. Citizen of What Cou	Intry?
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funera		J.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		, etc.
	Completed b		16a. Decedent's Usual Occupation (Give kind of work done during most of w fife. DO NOT use retired)	Specify SLA (16b. Kind of Business/Ir	
12 should be filed within h and Mental Hygiene. 7 is marked other than "raumatic event, the Men	o o	17. Father's Name (First, Middle, Last)		SCA FCC	D
2 should be and Ment is marked aumatic e	To	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or		ip Code)
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or T	own, State
Department Mportant:	once.	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	22. Name and Address of Facility WESSICK FUNEIGLE	ONE RO BOX EI	ce, VVID
Physicia /Medica Examine	n al	23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	E MYDCARDIAL quence of): DIABETES ME quence of):	ac or respiratory arrest,	Approximate Interval Between Onset and Death 2 Hours.
eath certif attending for use as	Physician/Medical I	d	al death 3 ☐Ectopic pregnancy	23d. Date of deliv Month	very Day Year
w requires that the deben signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not res		23e. Did tobacco use contribute to t	
n: The law rec ficate has been r, page 2 shou	Completed	HYPERTENSION END STAGE RENAL		performed? death? 1 Yes 2 No 1 Yes	opsy findings avallable impletion of cause of 2 □ No
ding Physician: After this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	R/Outpatient 3 DOA Other: 4 Nursing	eath (Check only one) Home 5 Residence 6 Other (Speci	ify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	1	28b. Time of Injury at Work? M 1 Yes 2 No ome, farm, street, factory, office	28d. Describe how injury occurred 28f. Location (Street and Number or Rur City or Town, State)	ral Route Number,
he Hospit : n 24 hours ne Funera	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knot on the basis of examination and manner stated.	owledge, death occurred at the time, date and pla ation and/or investigation, in my opinion, death oc	ce, and due to the cause(s) and manner as courred at the time, date and place, and due	stated. to the cause(s)
Som within	Ž	29b. Signature and title of certifier Yellow	, M.D. 29c. License number D 4 6	29d. Date signed (Month, MARCH 0	Day, Year) 2007
		30. Name and address of person who completed cause of death (Iter M. SHIR AZI, M.D., PENIN	· · · · · · · · · · · · · · · · · · ·		
S Regis	State	31. Date filed (Month, Day, Year) MAR 1 4 2007	ature Annal A		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 001 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** ELSIE 2007 KENNEDY G. MARCH 0. 23:16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y) 4-23-24 Birthplace (State or Foreign Country) NC 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 F Yrs. 82 **Director** 246-22-9013 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 □ No Director DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1330 MASS. AVE., N. W. 20005 S. The variation of the v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No WHITE þ Specify: 3 ☐ Widowed 4 ☐ Wivorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE SECRETARY/MODEL UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARTHUR R. COOPER MITTIE S. FAIRCOLTH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ELISE JOYNER, ESQ. I. AVE., N. W. #700 WASH., DC 20036 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) REMATORY 3-18-07 | CLINTON, MD 22. Name and Address of FacilityPINCKNEY-SPANGLER FUNERAL H. M. CREMATORY 21. Signature of Funeral Service Licensee 524 - 8TH ST.N,E. WASH., DC 20002 Ima 23a. Part1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOCK /Medical Examiner MATASTATIC (TERMINAL)OVARIAN CARCINOMA sif any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner PNEUMONIA burial-tra Due to (or as a consequence of): ACUTE RENAL FAILURE IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes XXNo 3 ☐ Probably 4 ☐ Unknown RESPIRATORY FAILUIRE TOXIC METABOLIC ENCEPHALOPASLY 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform HYPONATREMIA 1□ Yes XXVo 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, After this funeral s after death

Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Impatient 2 ER/Outpatient 3 DOA Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ACcrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a

To the Funeral State Registrar

who completed cause of death (Item 23a) (Type, Print) ZUNIGA MD

1500 FOREST GLEN RD. SILVER SPRING,

31. Date filed (Month, Day, 32. Registrar's Signa MAR 1 5 2007

29b. Signature and title of certified

filled in by

29c. License number

47867

29d. Date signed (Month, Day, Year)

MARCH 13, 2007

10b. County

Manor Care

5. Social Security Number

108-18-6495 Usual Residence of Decedent

10e. Street and Number

11 Marital Status

10a, State

MD

Director

Funeral

ģ

Completed

Be

ပ

17. Father's Name (First, Middle, Last) Ben Kreizman

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

Phyllis Kreizman - Wife 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place) 1 N Burial 2 □ Cremation 3 □ Removal from State GARDEN OF REMEMBRANCE 3/06/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Coronary Artery Disease

Due to (or as a consequence of):

Atrial Fibrillation

Failure To Thrive

Due to (or as a consequence of):

Physician /Medical Examiner Examine

and

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.

Baltimore, Maryland 21215-0036

with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF	FE	EMAL	E:
23	h.	Was	dece

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

edent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🗆 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

perform 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

				_			
Place	of	Death	(0	Check	only	one)	
			_				Т

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28c. Injury at Work? 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c, License number D57124

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715 Medical Center Drive, #201 Rockville, MD 20850 Truong Bao, MD

State Registrar

31. Date filed (Month, Day,



DHMH 17 Rev 1/2001

12

ORIGINAL

Division or Vital

that the death certificate be executed use as the burial-trar P.O. Box 68760, attending physician signed by t be detach Records, has To the Hospital or Attending Physician: funeral After death. filled in by the fr within 24 hours a

To the Funeral I

25. Was case referred to medical examiner? 1 ☐ Yes 21 No 27 Manner of Death

1 Natural 2 Accident

3 ☐ Suicide 4 ☐ Homicide

6 ☐ Could not be determined

5 Pending investigation

Hospital:

28a. Date of Injury (Month, Day Year)

1 Inpatient

2 ER/Outpatient 3 DOA 28b. Time of

26

319107

Division or Vital Records, P.O. Box 68760,	Baltimore, Maryland 21215-0036
al or Attending Physician: The law requires that the death certificate be executed a party of the law requires that the death certificate be executed as the release.	permit. Pages 1 and 2 should be filed within 72 hours after death wit Denotinent of Hoalth and Montal Hydiene
After this certificate has been signed by the attending physician and	Important; If item 27 is marked other than "natural", or items 23a c
sit	any injury or other traumatic event, the Medical Examiner must be
al	ance.

	Registrar		ertificate of	Death		Reg. No.		7
ın	1. Decedent's Name (First, Middle, Last) Kathryn Eleanor Ke	ller			2. Date of De Month March	Day 6	07	1:30 a
al : er	4a. Facility Name (If not institution, give street and number		4b. City, Town,	or Location of Death	1		ounty of Dea	th
71	Manor Care-Potomac	•	P	otomac			Montgo	merv
		. Age (In yrs. last birthda	ay) If Under 1 Yea	If Under 24 Hrs.	8. Date of Bir (Month, Da	th		thplace (State or Fore
	274-05-2445	91 Yrs.	Months Days	Hours Min.	Feb. 2			nnsylvania
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				·	10d. Inside City Lim
cţō	Maryland Montgomery	P	otomac					1 ☐ Yes 21x
Director	10e. Street and Number		10f. Zip Code			10g. Citize	en of What Co	ountry?
<u>a</u>	10714 Potomac Tennis La	ne		20854			USA	
Funeral	11. Marital Status 12. Was Deced Armed Force	ent Ever in U.S. 1	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14	 Race - Ame Black, Whit 	
ρ	3 Widowed 4 □ Divorced Year or Dat	No No	1 ☐ Yes 3/-XNo				Specify.Whi	
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Occi ive kind of work done e. DO NOT use retir	pation during most of work	king	16b. Kind	d of Business	/Industry
mpl	Elementary/Secondary (0-12) College (1-	for 5+)				0		
	17. Father's Name (First, Middle, Last)		Homemake	18. Mother's Nam	ne (First, Middle		n Home	
To Be	Harry H. Lutz			Fannie		maraen e	umamoj	
-	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Stree	t and Number or Ru	ral Route Numb	er, City or	Town, State, .	Zip Code)
	Gretchen Keller Brewer/	Daughter	1727 Gla	stonberry	Road,	Rockv	ille,	MD 20854
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from Si	cemetery, c	sposition (Name of crematory or other pl	' : 110	Date arch 21		ation - City or	Town, State
	4 □ Donation 5 □ Other (Specify)				2007			Virginia
	21. Signature of Funeral Service Licensee AppleMarke Parke		Francis Add 500 Unive					na. MD 20
	23a. Part1. Enter the disease, or complications that car shock, or heart failure. List only one cause on ear	used the death. Do not						Approximate Interval Between
	Immediate Cause (Final		m:-					Onset and Death 2 D
	resulting in death)	rdial Ische rasaconsequence of):	шта					2 0
	Coron	ary Artery	Disease					
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

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	Examir		4a. Facility Name (If not in			umber)		4b. City,	Town, or	Location	of Death		4	c. County of	Death		
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			23a. Part1. Enter the dise shock, or heart failu	e. List only	one cause on	each line.	1-		-	g, such as	cardiac	or respirator	y arrest,			Approximate Interval Betwo Onset and De	een
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a. 1	Carl		1001							5	. / - 4 -	2moi
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Division	Atten r dea ector by the	Certification:	3 Suicide 6 🗆	Could not be	28e. Plac	e of Injury - A	At home, farm, si					28f. Location	(Street a	and Number	or Rura	I Route Numbe	θ <i>r</i> ,
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	To the Hospitel or Attending Physician: The law requires that the death within 24 hours after death. To the Funersi Director: After this certificete hes been signed by the atter completely filled in by the funeral director, page 2 should be detached for u		29a. Certifier 1 ☐ €€ (Check only 2 ☐ M	ertifying Ph	ysician: To the	e best of my	knowledge, dea nination and/or is	th occurred	at the tim	e, date ar	nd place,	and due to the	he cause(s) and mann	er as st	ated.	
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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:45 PM Physician Keller Lewis 20 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F 198-20-6343 79 30, 1927 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2X No Director Hagerstown MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 17702 Burnside Ave. 21740 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Examiner 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4or 5+) Machinist Mack Truck 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Keller Orpha Shuman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i Mary Jane Keller/Wife 17702 Burnside Ave., Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 3/22/2007 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Nemmonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Seis Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine F-ailure that the death certificate be executed Acuta and resulting in death) Last Due to (or as a consequence of): Hypernalvemia Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed 2 □ No 2 0 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ho 1 Mnpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. ospital or Attending Physhours after death.
Ineral Director: After this y filled in by the funeral di To the Hospital of within 24 hours at To the Funeral D

Registrar

Medical

29b. Signature and title of certifier

29a, Certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1126

0066396

29d. Date signed (Month, Day, Year)

			1 - For State Registrar Amended #	State of Marylan gc,3/15/	d / Departme 07 <i>Certifica</i>	nt of Health and te of Death	Mental Hygien	LUU1	09819
	Physici /Medic		1. Decedent's Name (First, Middle, Las	Leonte	,		2. Date of Death	7 07	3. Time of Death
	Examir Funeral		4a. Facility Name (If no institution, give	ARE POTO	MAC	y, Town, or Location of Deat O TO M er 1 Year If Under 24 Hrs s Days Hours Min.	9C 1	C. County of Death	DOMCTY Iplace (State or Foreign Intry)
1	Director		Usual Residence of Decedent	M 2/XF 91 4	Yrs.	S Days Hours Will.	11 28 19	713 HC	10d. Inside City Limits
	he Maryla 8a-f ehov	Director	DC	loc. Gil	y, Town or Location AS	HINGTON	J		1 Yes 2 No
	eath with the 23a or 2	Funeral Dire	10e. Street and Number	12. Was Decedent Ever in U	W	200//		itizen of What Cou	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural', or Itema 23a or 28a-f ehow any injury or other traumatic avent, Ite Medical Examination Indiad at ance.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ★Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerl	o Rican, etc.)	Black, White	HITE
1215-0036	rithin 72 ho ne. nen "netur e Medicel	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) Collegé (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	vork dane durina most of wo	rking 16b.	Kind of Business/I	ndustry
and 21	s be filed w ntal Hygier ed other th	Be	17. Father's Name (First, Middle, Last)	1004	Phy310	18. Mother's Nar	(First, Middle, Maile	HEHI In Symame)	
Maryland	and 2 should ealth and Mer n 27 is marke ear traumatic	To	19a. Informant's Narrie/Relationship (7	(J)CT Type, Print) L(IA (SON)	19b. Mailing Addre	ss (Street and Number or Re	ural Route Number, City	or Town, State, Z.	ip Code) // \/ /0/5/)
altimore,	Pages 1 and nent of Health int: If Itom 27 iry or othar tr		20a. Method of Disposition 1 Burial 2 Ofermation 3 4 Donation 5 Other (Specify	Removal from State	ace of Disposition (Nemetery, crematory of	ame of other place)	Date 200.	ocation - City or 1	Town, State
Balti	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lice	1/0.	23. Name	and Address of Facility T MASON	F5 81V	I CLEVE	AND HVE
	Physician		23a. Part . Enter the disease of rooms shock, or heart failure. Ust only disease or condition resulting in death)	olications that caused the deat one cause on each line.	h. Do not enter the m	ode of dying, such as cardian			Approximate Interval Between Onset and Death
	/Medical Examiner	1.	Sequentially list conditions	b. Due to (or as a conseq					
	executed a and al-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq					
68760,	ificate be executed g physician and as the burial-transi	dicai	· ·	d					
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 ☐ Ectopic			23d. Date of deli Month	very Day Year
ds, P.	juires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco	_	the cause of death?
Division of Vital Records,		Completed					24a. Was an autopsy performed?	prior to c death?	copsy findings available ompletion of cause of
/ita	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				ath (Check only one)		
1	hysi this c	2	1 ☐ Yes 2 No		ER/Outpatient 3 1		lome 5 Residence		ufy)
sion (ding h	Certification:	27. Manner of Death 1 Statural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
Σ	Dir.		4 Homicide determined	building, etc. (Specif	y)		28f. Location (Street and City or Town, Sta	ite)	
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier 1. Certifying Phy (Check only one) 2 Medical Exam	/sician: To the best of my knoiner: On the basis of examina and manner stated.	wiedge, death occurre tion and/or investigation	nd at the time, date and place on, in my opinion, death occu	e, and due to the cause firred at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1059		9c. License number	1	ate signed (Month	, Day, Year)
0			30. Name and address of person who o	completed cause of death /lion		20054566	3/1	1107	
			Sunitha Bhogain	14702 C	henryL	eatterrac	E Silven	SPRING.	MD20906
A.	- Sta	te	31 Date filed (Month Day Year)	32. Registrar's Signa	iture		,	V	

			1 - For State Registrar	State of	Maryla	nd / Dep <i>Ce</i>		ent of He ate of L		ind Me	-	giene Reg. No	200	7 09	820
	Physici	an.	1. Decedent's Name (First, Middle, Las	1)						1	2. Date of De Month	ath Da	y Ye	3. Time o	of Death
	/Medi			DIK]	MARCH	11,	2007	8:55	A M
	Examir	ner	4a. Facility Name (If not institution, give 2705 NEWGLEN AVE		ber)			y, Town, or		f Death			. County of D		
25.	Francis I		5. Social Security Number 6. Se		7. Age (in vrs	. last birthday)	_	ESTVI ler 1 Year	If Under 2	24 Hrs.	9 Date of Bird		9	GEORGE 'S Birthplace (State	or Foreign
K gata	Funeral Director			_M 2 8∃#	56	Yrs.	Month		Hours	Min.	3. Date of Bird (Month, Da .0-13-1	950	Wa	country) D.	C.
5			Usual Residence of Decedent		1.0										
laryla	ehov F	7	10a. State 10b. County		10c. C	ity, Town or Lo								10d. Inside (City Limits s 2 ☐ No
the M	28a-1	Directo	Maryland Prince Ge 10e. Street and Number	orge's		Fo		tville Zip Code	<u> </u>			10a Ci	tizen of What		, 20,10
with	3a or		2705 NewGlen Aven	110			101. 2	20747	7			rog. Or	U.S.A.	•	
death	ms 2	Funeral	11. Marital Status	12. Was Deced		J.S. 13.	Was Dec			in? (Spec	ify Yes or No ican, etc.)	-	14. Race - A	merican Indian,	
after	or Ite	/Fu	1 ☐ Never Married 2 Married	Armed Ford 1 Yes If Yes, Give	2 [≸ No	1		ecity Cubar 2∰-No	Specify:	, Puerro R	ican, etc.)		C=== i6	hite, etc.	
17215-0036 within 72 hours after death with the Maryland	ural',	d by	3 Widowed 4 Divorced	Year or Da									V	√hite	
15 In 72	"nail	lete	15. Decedent's Edi (Specify only highest grad	de completed)		(Give	kind of v	ual Occupa vork done di use retired)	urina most	of working	7		and of Busine	ess/Industry	
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בו פוניים	nd Mental Hygiene. marked other than "natural", or Items 23s or 28s-1 ehow imatic event, itte Musical Examinar must be notilise at	Bec	17. Father's Name (First, Middle, Last)						18. Mother	's Name (First, Middle,	Maider	Sumame)		
aryiai should b	Mental arked o	10	Wesley R. W	atson					Dori	s E.	Chane	y			
Jar 2 sho	le m	17	19a. Informant's Name/Relationship (7)								Route Numbe				
တ့ <u>ဗ</u>	of Health and Menitem 27 le marke other traumatic	1 8	Thomas A. Ladik/hu 20a. Method of Disposition	sband	20b.	2705 Place of Dispo			ve. F	ores	tville	•		or Town, State	
Pages	t: If it		1 Burial 2 ☐ Cremation 3 ☐ I		tate _	cemetery, crei dar Hil	matory`o	other place						Maryland	
altimore, mit. Pages 1 ar	Department of I Importent: If It ony injury or o		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens					and Address			2007	Duit	. rand , i	iai y rand	
Balt	e d in g		1 De du	- MO1	111						A Ave.	Sui	tland.	Md. 207	46
3			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that ca	used the dea	th. Do not en	ter the m	ode of dying	, such as c	ardiac or	respiratory ar	rest,		Approxima Interval Be	tween
Ph	ysician		Immediate Cause (Final disease or condition	. at	_	clerat	,				la I		JU	Onset and	Death
	Medical kaminer		resulting in death)	Due to (c	r as a conse	quence of):					-				
48.50		7.	Sequentially list conditions,	b. Due to (o	r as a conse	quence of):									
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D, exec	an and rial-tra		that initiated events resulting in death) Last	Due to (o	r as a conse	quence of):									
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J 5	B 8	by Physici	Part II. Other significant conditions co	ntnbuting to dea	ath but not re	sulting in the u	nderlying	cause give	n in Part I,		23e. Did to	obacco	use contribute	e to the cause of	death?
rds quire	been sign should be										X	res 2	□ No 3 □	Probably 4 🗆	Unknown
VITAL RECORDS, sician: The law requires t	w CI	ompleted									24a. Was		24b. Were	autopsy findings	available
r å	certificate ha irector, page	Com										rmed? 2 No	death	to completion of o o? ∕es 2 □ No	,ause 01
VITA Ician:	certific irector,	Be	25. Was case referred to medical examiner?	13-1						of Death (Check only o				
	this ald	၉	1 Yes 2 No			ER/Outpatier			4 Nurs	sing Home			6 □Other (S	ipecify)	
E E	h. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month	Day Year)	28b. Time of Injury	м	28c. Injury Work	at ? es 2 □ N		d. Describe h	iow inju	ry occurred		
DIVISION OF I or Attending Phy	after death. I Director: After d in by the funera	fica	3 Suicide 6 Could not be	28e. Place o	of Injury - At h	nome, farm, str					f. Location (S	Street an	id Number or	Rural Route Nur	nber.
בַּ בַ	= 5 5	Certification:	4 Homicide determined	building	g, etc. (Spec	ify)					City or Tou	vn, State	•)		
• Hospital or	Fur ely	edical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the b	sis or examin	owledge, deat ation and/or in	h occurre vestigation	d at the time on, in my opi	e, date and inion, death	place, an	d due to the d at the time, d	cause(s)	and manner d place, and c	as stated. due to the cause(s)
To the	within 24 h To the Fur completely	Me	29b. Signature and title of certifier				2	9c. License	number				-	onth, Day, Year)	
^			> Y Mirande	, m	D			14	3274	4		N	larch	13, 200	77
LI	8)		30. Name and address of person who of Imelda Miranda,	ompleted cause	of death (fte	m 23a) (Type, h Osbo)	Print)	Road #	106	Uppe	r Marl	boro	,Md. 2	20772	
10	Sta	te	31. Date filed (Month, Day, Year)							-PP-			•		
	Registr		MAR 1 4 2007	1	1.	ature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 03 2007 10:39 AM 06 HENRY LICHTENSTEIN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY BETHESDA SUBURBAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–15–1921 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Hours POLAND 85 579 42 3050 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County KENSINGTON 1 ☐ Yes 2 No MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code IISA 4301 KNOWLES AVENUE 20895 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TOWN GUIDE 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LAJA REICHMAN ICEK MAYER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12TH STREET NE, WASHINGTON, DC 20002 219 ALEXENDAR LICHTENSTEIN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 3-10-07 ALEXANDRIA, VA 4 Donation 5 Dother (Specify) 22. Name and A DARSHALL'S FUNERAL HOME OF MD, INC. 4308 SUITLAND RD, SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau

Pages 1

that the death certificate be executed

attending physician

Division or Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

Be

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Funeral

Director

items 23a or 28a-f shoi iner must be notified at

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or other traumatic event, the Medical Examiner

Maryland 21215-0

Baltimore,

n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in

page 2 should

has

or Attending

the Hospital

Examiner Physician/Medical þ Completed Be Certification: To

Medical

State

29b. Signature and title of certifier

ALPANA GOSWANI,

MAR 1 4 2007

31. Date filed (Month, Day, Year)

30. Name and addr as of person what completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

MD,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CONGESTIVE CARDIOMYOPATHY Due to (or as a consequence of): c	7.0
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
25. Was case referred to medical examiner?		n (Check only one)
1 ☐ Yes 2 ☐XNo	Hospital: 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	in (Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Could not to determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and place, iminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	

29c. License number

D-27660

29d. Date signed (Month, Day, Year)

317107

Registrar DHMH 17 Rev 1/2001 8600 GEORGETOWN RD, BETHESDA, MD 20814

M.D.

		•	For State	State of Ma	aryland /	•	artment of H		Mental Hy	giene	007	00022
			Registrer 1. Decedent's Name (First, Middle, La	ist)			timouto of E		2. Date of D			3. Time of Death
	Physici		LINDA LOUISE	LACEY					MARCI	1 2 2 2	200 ^{Year}	10:15a ^M
}	/Medic Examin		4a. Facility Name (If not institution, given				4b. City, Town, or	Location of Deat			unty of Death	.0.134
	Exami	eı	Chester River				Chest	ertown		Ker	n t	
	Funeral				e (In yrs. last b	birthday)	If Under 1 Year	If Under 24 Hrs			9. Birthp	ace (State or Foreign
	Director		222-28-1974	1□M 2 X F	63	Yrs.	Months Days	Hours Min.	Jan	18 194	14 Del	aware
	P .		Usual Residence of Decedent									
	aryla show	_	10a. State 10b. County		10c. City, To		cation				, "	0d. fnside City Limits 1 Yes 2 No
	8a-f	Scto	MD Kent		Mass	sey	1			40. 031		
	with ti	급	10e. Street and Number				10f. Zip Code			iug. Citizen	of What Coun	try?
	s 23	erai	12072 Galena	Rd .	Ever in II C	12 1	21650 Was Decedent of Hi	enanio Origina /9	necify Ves or N		S.A. Race - Americ	an Indian
36	permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. important: if item 27 is marked other then "netural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	Amed Forces? 1 □ Yes 2 反 I If Yes, Give Year or Dates:		1	f Yes, specify Cubai	Specify:	to Rican, etc.)		Black, White,	
21215-0036	tura	edt	15. Decedent's E		16	a. Dece	dent's Usual Occupa	ition		16b. Kind	of Business/Inc	lustry
5	in 72 n "n	Completed	(Specify only highest gr	ade completed)		(Give	kind of work done d DO NOT use retired,	uring most of wo	rking			,
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ਰੂ	Hyg other	BeC	17. Father's Name (First, Middle, Las.)				18. Mother's Na	me (First, Middle	-		
ä	lid be kenta ked ic sv	To B	George Washir	ngton Lac	еу			Emma :	France	s Your	ng	
Maryland	shou and N amer umat		19a. Informant's Name/Relationship				g Address (Street a					
_	alth alth 27 is		Margaret Lacy	/ (siste	r-in-i	law)	1104 B	ear Rd	. New (Castle	e, DE.	19720
ē,	of He itsm		20a. Method of Disposition		20b. Place cemer	of Dispo	sition (Name of natory or other place	a)	Date	20c. Locati	ion - City or To	wn, State
altimore,	Page nent c int: if		1 Strial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci				Cemete		27/07	Wiln	ningto	n, DE.
Balti	permit. Depertminimports sny inju		21. Signature of Film rat Survivo Lice		M0051	Ga	Name and Address lena Fu 8 West	neral 1	Home of	E Ster	ohen L	Schaech
			23a Part1. Priter the disease, or consheck, or heart failure. List only	aplications that caused	the death. D	o not ent	er the mode of dying	g, such as cardia	c or respiratory	arrest,	MD . Z	Approximate
>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Resp	. L.	<u>~</u>	Failur	في				3 WOLKS
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oʻ	icate be executed physicien and s the burial-transli	EX	resulting in death) Last	Due to (or as	a consequenc	e of):						
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Box	that the death certifii ed by the attending I detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy	th 3.Γ	Ectopic pregnancy			23d.	. Date of defive	*
<u> </u>	deal	sicia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at 9□Unknown			Other (specify)				Month	Day Year
o.	at the	Ę.	9 Unknown						-1927			
Division of Vital Records, P.O.	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	۾	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the u	nderlying cause give	n in Part I.		tobacco use Yes 2□N		ably 4 known
Reco	he law re e has be age 2 sho	Completed							peri	onned?	prior to cor death?	psy findings available npfetion of cause of
ā	ician: Th certificate rector, pag	Ö	25. Was case referred to medical					26 Place of De	1 ☐ Yes ath (Check only	2 No	1 🗆 Yes	2 No
>	Physician: r this certific ral director,	0 8	examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ER/	Outpatier	t 3 DOA Othe		Home 5□Res		Other (Specifi	<i>(</i>)
0	g Physical this	E	27. Manner of D ath	28a. Date of Inju	ry 28b	. Time of	28c. Injury	at	28d. Describe			,
<u>0</u>	Attending ir death. sctor: After by the fune	atio	1 Naturaf 5 ☐ Pending 2 ☐ Accident investigated	(Month, Da	y rear/	Infury	Work M 1□\	/es 2 □No				
<u>S</u>	Atta	1	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Inj		farm, str	eet, factory, office				lumber or Rura	I Route Number,
ō	s afte	Certification;	- C HOMILOUG	building, et	c. (Specity)				City of 10	wn, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying P	hysician: To the best miner: On the basis o	of my knowled	lge, deatl	occurred at the tim	e, date and place	and due to the	cause(s) and	d manner as st	ated.
	ths H tin 24 ths F iplete	ledical	one)	and manner sta	ated.							1
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	7.			29c. License	number	00	29d. Date s	igned Month,	Diy, Year)
			400	Cenas	mm	و۔	1)11	042	7 7	3	123/	0
	5		30. Name and address of person who Wayne D. Ber	njamin, M	.D. 6	6602	Print) Church	Hill F	Rd. Che	stert	own,	MD. 21620
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 8 200	32. Registr	ar's Signature	Joan						

07-02018

		ent of Health and Mental Hygiene ate of Death	2007 09823
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last) Ral Kian Lo	2. Date of Deat Month March 15,	Day Year 0715 hrs
· ·	Facility Name (if not institution, give street and number) Woods near 8907 Boyelder Drive	4b. City, Town, or Location of Death Laurel	4c. County of Death Prince George's
Funeral Director	5. Social Security Number 213-75-2761 1 X M 2 F 32	nday) If Under 1 Year If Under 24Hrs. 8. Date of Bin	th(MM/DD/YYYY) 9. Birthplace (State or Foreign 2, 1974 Consumma
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of		10d. Inside City Limits
land f show once.	Maryland Prince George's	Laurel	1 Yes 2 X No
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene lant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be aptified at once. To Be Completed by Funeral Director	10e. Street and Number 8907 Bovelder Drive	10f. Zip Code 20708	Og. Citizen of What Country? Burma
er death with t , or items 23a r must be not	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
s after or rail", on niner n	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify: Decedent's Usual Occupation (Give kind of work done	Specify: Asian
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by F	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired)	
-003(within giene her that he Medic	17. Father's Name (First, Middle, Last)	Sushi Chef 18. Mother's Name (First, Middle, N	Restaurant Maiden Surname)
be filed and Hy cent, the Be C	Hmun Iap	Fam Par	
ID 21 should and Me 7 is ma matic ever		Mailing Address (Street and Number or Rural Route Num 907 Bovelder Drive, Laurel,	
re, N 5 1 and 2 f Health If item 2 er traur	20a. Method of Disposition 20b. Place o	f Disposition (Name of cemetery, Date	20c. Location - City or Town, State
timo Pages tment of tant: I	4 Donation 5 Other Specify:	Heaven Cemetery 2007	Silver Spring, Maryland
Bali permit Depar Impor	21. Signature of Funeral Service Licensee	27 Man 21 Address of Collylins Funera 500 University Blvd, W, S	
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or respiratory arre	est, shock, or heart Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a Isopropy1 alcoho1 into Due to (or as a consequence of):	coxication	Death
iner	Sequentially list conditions, if any, leading to immediate Cause Fit of the daying Cause		
d ansit Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.		
60, ate be executed hysician and e burial - transit	X UNPENDED AMENDED #23a,27,28a-f,perMF	1,g865,3/30/07 TT	
box 68760, the death certificate be executed the death certificate be executed when the attending physician and ched for use as the burial - transi Physician/Medical E)	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2		23d. Date of delivery Month Day Year
Box 687 e death certifice the attending p ed for use as th	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)	
ords, P.O. Box 6876 w requires that the death certificat s been signed by the attending ph should be detached for use as the oleted by Physician/M	Part II. Other significant conditions contributing to death but not resulting		bacco use contribute to the cause of death? 2 ✔ No 3 Probably 4 Unknown
ds, Fequires een sign build be eated the		24a. Was	an 24b. Were autopsy findings available
7 2 2 2 2		autop perfo 1 ✓ Yes	rmed? death?
tal Rician: T	25. Was case referred to medical examiner?	26 Place of Death (Check only one) utpatient 3 DOA Other Nursing Home 5	
of Vil	1 Yes 2 No lospite 1 Inpatient 2 ER/Ou 27. Manner of Death 28a. Date of Injury 28b.		Residence 6 Other Scene
ion c tending eath. tor: Af the fun	1 Natural 5 Pending (Month, Day,Year) Pnd 3/15/2007 Fnd	17:00 am 1 Yes 2 X No unk	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that twithin 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be deate ledical Certification: To Be Completed by F.		arm, street, factory, office building, etc. 28f. Location (sor Town Staurel, M	Street and Number or Rural Route Number, City state) near 8907 Bovelder Dr.
To the Hospital within 24 hours To the Funeral completely filled	one) 2 Medical Examiner: On the basis of examination and/or in	ath occurred at the time, date and place, and due to the caus investigation, in my opinion, death occurred at the time, date	
To with	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) March 16, 2007
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	Walter 10, 2007
	Susan Hogan MD. Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day Year) 2007 32 registrar's Signature	Spection	
DHMH 17 Rev 1/2001	OR	IGINAL	

Physic		Registrar	201	Co	ertificate of	Death		Reg. No. 2 0 0	7 098
,,	ian	Decedent's Name (First, Middle, L Sung	Hyun	Lee			2. Date of Dea Month	Day Y	3. Time of Dea
/Medi Exami		4a. Facility Name (If not institution, gi			4h Cihr Town	or Location of Death	March	4c. County of	
L. Xaiiii	Her	Holy Cross Ho		,		r Spring		Montgo	
uneral	Г		Sex 7. A	ge (In yrs. last birthda	y) If Under 1 Yea	r If Under 24 Hrs.			Birthplace (State or Fo
irector		577-82-9297 Usual Residence of Decedent 10a. State 10b. County	1 ⊠ M 2□F	82 Yrs.	Months Days	Hours Min.	9/10/		eoul, Kore
ed at	5	Md Montgo	omerv	10c. City, Town or Silver	Spring				10d. Inside City Li 1 ☐ Yes 2 ☐
286-1	ect	10e. Street and Number	J 2		10f. Zip Code			log. Citizen of Wha	
38 00	Funeral Director	440 University	v Blvd.Ea	ast #211	209	03	,	USA	it Country !
E B	ners	11. Marital Status	12. Was Deceden		. Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No-		American Indian,
ireno. Ita Medical Examinar musi ce notified at Ita Medical Examinar musi ce notified at	1 by Fu	1 ☐ Never Married 2反 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No	If Yes, specify Cu 1 ☐ Yes 2 🔀 No		Rican, etc.)	Specify:	^{White, etc.} Asian
Medical	Completed by	15. Decedent's 8 (Specify onty highest gi Elementary/Secondary (0-12)	ducation rade completed) College (1-4or	(Giv	edent's Usual Occure kind of work done DO NOT use retire	upation e during most of work ed)	king	16b. Kind of Busin	ess/Industry
-	E O	8	College (1-40)		er/Oper	ator		Groce	ry Store
arked other atic event,	To Be (17. Father's Name (First, Middle, Las Ki Young Lee	t)			18. Mother's Nam Ki Nu	e (First, Middle, I	Maiden Surname)	
27 ie m r treum		19a. Informant's Name/Relationship James Lee/Son	(Type, Print)			lett Blv			_{te, Zip Code)} inia 2201
item		20a. Method of Disposition		20b. Place of Disp				20c. Location - City	
T, o		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation /5 ☐ Other (Speci	Removal from State		f Heave	n 3/14	/2007	Silver	Spring, M
importent: if iter any injury or oth		21. Signature of uneral Service Dice	enel.	F	22. Name and Addr HILIP D	•ss of Facility RINALDI	FUNER	AL SERV	ICE,P.A.
sician ledical aminer		disease or condition		Ta		ing, such as cardiac			Onset and Dea
	ical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. COPD Due to (or as	cystic Luss a consequence of): s a consequence of): s a consequence of):					Onset and Dea
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1- State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygiei	0.0.0.0
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al	JAM ES McCorkLE 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	3	6 2007 Spm M 4c. County of Death
	Examin	ier	BRADFORD OAKS NURSING HOME	CLINTON		RINCE GEORGES
	Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthda) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Oay, Ye August 22	9. Birthplace (State or Foreign Country) 1905 North Carolina
	yland		10a. State 10b. County 10c. City, Town or I	.ocation		10d. Inside City Limits
	e Mar	ctor	MD Prince Georges Forestvi	.11e		1. Yes 2□No
	with th	Dire	7169 Cross St. #203	10f. Zip Code 20747	10g.	Citizen of What Country? USA
	Jeath TIS 23	eral		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
92	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Itams 23a or 28a-f show int. The Medical Examiner must be notified at	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 ANo	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: Black
Ö	hours tural',	ed b	3 Wildowed 4 Divorced Year or Dates:	edent's Usual Occupation	1eb	Kind of Business/Industry
21215-0036	hin 72 9. an "na Madic	plet	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing	
	ed with ygiene yar tha	Com	3rd Pho	tographer		Private
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Modeal Examiner must be notified at one.	To Be	17. Father's Name (First, Middle, Last) Thomas McCorkle	18. Mother's Name	e (First, Middle, Maid Allen	len Sumame)
ary	shoul and M s marl	1		ling Address (Street and Number or Run		
χ, Σ	and 2 lealth m 27 I	1		Cross St. #203, F		
nore	ages 1 int of H t: If ita		1 FT BUDAL 21 I Cremation 31 Hemoval from State 1	ematory or other place)		Location - City or Town, State
ä	mit. Poartme sortani rinjury			on National Cem.3/ 22. Name and Address of Facility Jo		enkins Funeral Home
ä	permi Depa Impo any ir		Beha Johnson	716 Kennedy St. NW		
	Pnysician	10 1	23a. Pert1. Enter the disease, or confidential that caused the death. Do not enshook, or heart failure. Ust only one cause on each line. Immediate Cause (Final disease or condition Atheroscleroti	nter the mode of dying, such as cardiac o		Approximate Interval Between Onset and Death Years
ľ	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of):			
760,	ate be executed thysician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):			
687	physik	edical	d.		-	
Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Me		□Ectopic pregnancy		23d. Date of delivery Month Day Year
P.O.	res that the death cer igned by the attendin be detached for use	ysic	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Foal
	ss that gned b	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Division of Vital Records,	w require been si should b				1 Tes	2No 3 Probably 4 Unknown
Rec	The law te has b	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ta		a	25. Was case referred to medical	26 Place of Deat	1 ☐ Yes 2 2 1 in (Check only one)	No 1 Yes 2 No
<u>></u>	Physician: rthis certificaral director, I	To B	examiner? 1 ☐ Yes 2 🎖 No	Other		6 ☐Other (Specify)
0 0	Attending Ph er death. rector: Alter th by the funeral	on:	27. Manner of Death 1 X Natural 5 ☐ Pending 28a Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?	28d. Describe how in	
isio	or Attending after death. Director: After in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	M 1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Rural Route Number,
2	- 2 = c	Certi	4 Homicide determined building, etc. (Specify)		City or Town, St.	
	To the Hospital of within 24 hours aff To the Funeral Discompletely filled in the Funeral Discompletely filled in the Funeral Discompletely filled in the Funeral Discompletely filled in the Funeral Discompletely filled in the Funeral Discompletely filled in the Funeral Discompletely filled in the Funeral Discompletely filled in the Funeral Discompletely filled in the Funeral Discompletely filled in the Funeral Discompletely filled in the Funeral Discompletely	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or interpretation.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To tha complete	Me	29b. Signature and title of certifier	29c. License number D19431		Date signed (Month, Day, Year) arch 8, 2007
			·		l Pi	arch 0, 2007
_			30. Name and address of pe completed cause of death (Item 23a) (Type Frank M. Ryan, M.D. 11701 Livingston	Rd. #203, Ft. Was	shington,	MD 20744
	Sta Registr	150	31. Date filed (Month, Day, Year) MAR 1 5 2007 MAR 2 5 2007 MAR 32. Registrar's Signature— Special Section 1. Special Secti			

07-02091 Jose Alberto Ros		otate of Marylana / Bepartment	of Health and Menta		gible. 2007	0982
		For State Registrar Amend 19a, per Inf, C867, 5/1/07 To ertificate		Re	eg. No.	
Physicia Medical Examir		1. Decedent's Name (First, Middle, Last) Jose Alberto Rosario M	arroquin	Date of Deat Month	Day Year	3. Time of Death 0958 hrs
ZAGIIII		JOSE ALBERTO ROSARTO MAROQUIN 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	March 17,	4c. County of Death	0938 1118
manuel		406 Brown Street	Federalsburg		Caroline	
Funeral	7	5 Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 2			hplace (State or
Director		562-12-9082 1XM 2 F 26	Months Days Hours	Min. 11-02-	1980 Foreign	Mexico
À	- 1-	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Loc				
ow any		, , , , , , , , , , , , , , , , , , , ,				10d. Inside City Limits 1 Yes 2 X No
with the Maryland s 23a or 28a-f show a		Maryland Caroline Federa 10e. Street and Number	lsburg 10f. Zip Code	10	og. Citizen of What Coun	
he Ma 1 or 28 iffed 2	ei	406 Brown Road	21632		Mexico	uy:
with t	ᆵ	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin?	(Specify Yes or No-		can Indian, Black,
death or iter	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.)	White, etc.	
s after ral", uiner,	<u>8</u>	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify.Me			kican
hour "natu			ent's Usual Occupation (Give kind most of working life. DO NOT use		16b. Kind of Business/Ir	ndustry
36 hin 72 e. than	읦	Jak 2	ken Catcher		Peterson E	nternrise
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Completed	17. Father's Name (First, Middle, Last) Bersain Rosario Sanchez		lame (First, Middle, M		meer pribe
121 be fill ental F rrked	Be_	Bersain Rosario	-Ros	a Marroqui	n Guanan	
D 2, should and M. is ma	ို	Veronica Kosario Marroquin	ng Address (Street and Number	r or Rural Route Num	ber, City or Town, State,	
, MD and 2 sho ealth and cm 27 is	-		Harmony Road,	_	laryland 216	
Ore Besling tof Hi		1 ABurial 2 Cremation 3 Removal from State crematory or	other place)	INK Date	SALK	idwii, diale
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	+		Municipal Cem. Name and Address of Facility		Huehuetan, Ch	oapas
Ba Perm Depa Injur	- [a movie 11. Show	Bennie Smith I 426 Dover Stre	Funeral Ho	me me Maryland	21601
Physician	ď	23a. Part I. Enter the disease, obomplications that caused the death. Do not ente failure. List only one cause on each line.	the mode of dying, such as card	ac or respiratory arre	est, shock, or heart	Approximate Interval
/Medical Examiner	1	Immediate Cause (Final disease a Acute alcohol intoxication	.on			Between Onset and Death
	-	or condition resulting in death) Due to (or as a consequence of):				
	P	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	티	cause. Enter Underlying Cause (Disease or injury that initiated				
ited d ansit		events resulting in death) Last Due to (or as a consequence of): d.				
executian an ial - tr	Physician/Medical		20a-c, per, ME, FH	, G866, 4/6/	07 TT	
760, cate bo	ğ	IF FEMALE: 23c. If yes, outcome of pregnancy	00,3/30/0/11		23d. Date of delivery	<u> </u>
Box 68760 e death certificate be the attending physical for use as the bu	ian	past 12 months?	Fetal death 3 Ectopic pr	egnancy	Month D	ay Year
BOX death	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		1	
O. I at the d by ti		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to t	he cause of death?
ires the signe	d by			1 Yes	2 No 3 Proba	ably 4 Unknown
ords w request should	Completed			24a. Was a autops		opsy findings available impletion of cause of
Reco	E			perform		s 2 No
ian:	Be -	25. Was case referred to medical examiner?	26 Place of Death (Ch	eck only one)		
1 of Vital Records, P.O. Box 68760, fing Physician: The law requires that the death certificate be execut. After this certificate has been signed by the attending physician and finneral director, page 2 should be detached for use as the burial - transference.	의	1 Yes 2 No Inpatient 2 ER/Outpatie			Residence 6 Other:	Scene
n ol ding l		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of (Month, Day, Year) 1 Natural 5 Pending 12.1.2 (17, 70007) 12.1.2 (17, 70007)	1 You 3 TING		low injury occurred	
SiO Atten r death ector: by the	cati	2 Accident Perioding Find 3/17/2007 Find 8:	Walii — A	uik	troot and Number or Dur	al Pouto Number City
Division of Vital Records, P.O spital or Attending Physician: The law requires that thours after death neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac	Certification:	3 Suicide 6 X Could not be determined (Specify) house	eet, ractory, office building, etc.	or Town, St	treet and Number or Rur tate) n St. Federals	
sspi hou y fill		29a. Certifier 1 Continue Physician. To the best of my knowledge, death age	curred at the time, date and place			
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.				
E.8 E.8	울	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

Jan &

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 18, 2007

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year) MAR 2 3 2007

Pamela E. Southall, MD Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Year March 10, Physician 6:50 P M Betty Arthur Martin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Casey House Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year April 2, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 M 2 XF Ĭ 931 Virginia 249-46-2790 75 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2000. any lightly or other traumatic event. The Madical Confession of the magnetic page 1. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 3005 S. Leisure World Blvd. #802 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Crossing Guard Public Safety 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Kirby John Arthur ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela M. Stigile/daughter 9900 Woodland Drive Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Crematory | 03/13/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a <u>Colon Cancer</u> disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2X No Be 26. Place of Death (Check only one) Hospital: Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ \square Other (Specify) $_{hospice}$ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred

The law requires that the death certificate be executed P.O. Box 68760. Records, certificate Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

27. Manner of Death 1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

Medical

5 ☐ Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

🛣 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier mikes m Dilliams

29c. License number HO058032 29d. Date signed (Month, Day, Year) arch 12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia M. Williams, D.O. 6001 Muncaster Mill Rd. Rockville, MD 20855

(S) AD State Registrar

31. Date filed (Month, Day, Year) MAR 14 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State o	f Maryla		artment rtificate			nd M	ental F	lygiei Reg.	6 U	07	09828
			Decedent's Name (First, Middle	, Last)							2. Date of	Death			3. Time of Death
	Physici /Medic		Josef Mark M	ickievi	CZ						March		Day • 200	Year)7	5:25 PM
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, 1	Town, or L	ocation of	Death		- 1	4c. Count		
			Kline Hospic				Mt.	Air	Y				Fred	deric	k
	Funeral Director		208-50-8042	6. Sex 1 ♣ M 2 ☐ F		. last birthday) 44 Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of (Month, Jan.	Dav. Ye.	^{ar)} 1963	9. Birthp Cour Penns	place (State or Foreign http: ylvania
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. C	ity, Town or Lo	cation							1	IOd. Inside City Limits
	Manyi faho	ō	MD Freder	ick	Lia	msville									1 ☐ Yes 2 🔯 No
	the 28a	rect	10e. Street and Number		-3		10f. Zip	Code	-			10g.	Citizen of	What Cour	ntry?
	3a or	Funeral Director	8903 Berwick P1	ace S.			2175	4				USA	A		
	death	ner	11. Marital Status	12. Was Dec Armed Fo	edent Ever in l	J.S. 13.	Was Deced	ent of Hisp	panic Orig	jin? (Spe	cify Yes or	No-		ce - Americ	
စ္က	or its	E	1 X Never Married 2 ☐ Marri	ed 1 ☐ Yes If Yes, Gi	2 📉 No		1 ☐ Yes 2		Specify:	T dono.	noun, oto.,			[∱] ∵ Whi	
8	ural',	q p	3 Widowed 4 Divorced	Year or D	ates:	1.40- 0		10				1 401			
1 2	n 72 nat	Completed by	15. Decedent (Specify only highes	t grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done du		of workir	ng	160	. Kind of E	Business/In	austry
72	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Purch	asing	Ager	nt			M	i11wo	rk Co	mpany
פַ	be filed within 72 hours after death with the Maryland stal tyglene. do other than "natural", or itema 23a or 28a-f ahow avent, Ira Medical Exam Lar must be notified at	Be C	17. Father's Name (First, Middle, I	ast)				1	8. Mother		(First, Mid		den Sumar	me)	
lar	uld be Aenta rked ric a	To B	Stanley A. Mick	ievicz				P	Anna	M. E	Edinge	er			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked othar than "natural", or items 23a or 28a-f show any injury or othar traumatic avant, Ita Mudical Examination in the indiffied at once.		19a. Informant's Name/Relationsh Gina Cordova/PO				ng Address Sumne							, State, Zip	o Code)
altimore,	ss 1 a of Hea itam		20a. Method of Disposition	2 CD	1	Place of Dispo	sition (Nam	ne of ther place)		D	ate	20c	. Location	- City or To	own, State
Ē	Page ment: if ant: if ury o		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (Sp		Ch	esapeak	e Cre	mator	ry O	3/13	3/07	Be.	ltsvi	11e,	MD
Balt	permit. Departimport. any inj	1	21. Signature of Funeral Service L	Ho and	t. M		ing H								784 , MD 21029
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on e	caused the dea										Approximate . Interval Between
	Physician		Immediate Cause (Final disease or condition	Car		espira	tou	Q	me	+					Onset and Death 10 minutes
	/Medical		resulting in death)	Due to	(or as a conse		(•					-
	Examiner	_	Sequentially list conditions,	b. Ke	trouir	al 1	njec	100)					1	syears
П	ed isit	Jine	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to	(or as a conse	quence or):	J								
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c	(or as a conse	quence of):									
8760,	icate be executed physicien and s the burial-transit	dicai E	W	d											
687	ificate g phy as the	edic		0.									_		
Вох	andin use	In/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregr		Ectopic pre	200 2004						ate of delive	ery
B	that the death certificated by the ettending of detached for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (spe					_	M	onth	Day Year
<u>Р</u> .	at the	Phy	9 Unknown												
Division of Vital Records,	The law requires that the death certifi lie hes been signed by the ettending i sage 2 should be detached for use as	ed by	Part II. Other significant condition	e diar	Thea	•	naerlying ca	iuse given	in Paπ i.			□ Yes	2 No		he cause of death? pably 4 Unknown
ဝင္	e law re hes be je 2 sho	Completed					, , , , , , , , , , , , , , , , , , , ,				24a. W	has an utopsy	24b.	Were auto	ppsy findings available impletion of cause of
<u> </u>	The sete h page	Son									1 ☐ Ye	erformed		death? 1 ☐ Yes	
/ita	iclan: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Massitely						of Death	Check on	y one)			
of	Phys this al dir	. To	1 ☐ Yes 2 Ø No 27. Manner of Death	Hospital: 1 28a. Date	·	28b. Time o			4 Nui		ne 5 R			her (Specif	n Hospice
L _O	ding h. After fune	tion	1 Matural 5 ☐ Pending	(Mon	th, Day Year)	Injury	M	Bc. Injury a Work? 1 □ Ye	n es 2.∐N		.bu. Descri	De HOW II	njury occu	1100	
/isi	Attanding Physiclan: r deeth. actor: After this certific by the funeral director.	ifica	3 Suicide 6 Could n	ot be 28e. Place	of Injury - At I	home, larm, str								ber or Rura	al Route Number,
á	al or s efter	Certification:	4 Homicide	build	ing, etc. (Spec	eify)					City or	Town, St	tate)		
	To the Hospital or Attending Physician: The inwithin 24 hours either death. To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier 1 Certifying (Check only one)	g Physician: To the Examiner: On the b and man	e best of my kn easis of examin ner stated.	nowledge, death nation and/or in	h occurred a vestigation,	at the time, in my opin	, date and nion, deat	d place, a	and due to t ed at the tin	he cause ne, date	e(s) and m and place,	anner as s , and due to	tated. the cause(s)
	within To th comp	Me	29b. Signature and title of certifier	,			29c.	. License r	number			29d.	Date signe	ed (Month,	Day, Year)
)			Y (Sar	detch	my	\supset		DB	357	-01		1	3/12/	107	
)02	>		30. Name and address of person	who completed cause	se of death (Ite	em 23a) (Type,	Print)	re (Juni		17	hn	Ho	pkr	ıs
	Sta	te	31. Date filed (Month, Day, Year)	32.	egistrar's Sign	nature			-1111		01	J. 71.		1	
•	Registr	ar	MAR 1 4	2007	Bur.	N. A	me	•							

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			1 - For State Registrar	State of Ma	aryland / De <i>C</i>	oartmer e <i>rtifica</i>	nt of H te of L	ealth a Death	and M		giene Reg. No.	07	098	29
	Dhamis		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ith Day	Year	3. Time of I	Death
	Physici /Medi		Bette C. McIntir	e						03	12	2007	2037	М
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location o	l Death		4c. Cou	nty of Death		
			Atlantic General H	ospital		Ber	lin				Word	ester		
	Funeral		Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthda	y) If Unde Months	r 1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birtl (Month, Day	h /, Year)	9. Birth	olace (State or ntry)	Foreign
	Director		000-32-7112	JW SCAL	72 Yrs.					12 03		NY		
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							10d. Inside City	v Limits
	etarylan etary	5				Coodion							1. Yes	-
	he N	Director	MD Worces 10e. Street and Number	ter	Berlin	101.7	- 0 - 1 -				10- 01	-4.1404.00		
	with a or						p Code			-	10g. Citizen		nury :	
	a 23	Funeral	55 Moon Shell DR	12, Was Decedent	Fuer in H.C. 1		811		-:-2/0	-4. Vaa Na	USA	Race - Ameri	oon Indian	
	item Item	un	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?		II Yes, spe	ecify Cuba	n, Mexican	, Puerto F	cify Yes or No- Rican, etc.)		Black, White,		
36	Ir, or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	1 🗆 Yes	2 ⊠ No	Specify:			Spe	cify: Wh:	ite	
ö	72 hours after deeth with the Maryland haturel, or Heme 23e or 28e-f ehow disel Exeminar must be notified at	Completed by	15. Decedent's Edu		16a. De	cedent's Usu	ial Occupa	ation			16b. Kind o	Business/In		
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212	d within piene. r then.	E	Elementary/Secondary (0-12)	College (1-4or 5		wner/	Opera	ator						
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Maryland 21215-0036	2 should be filed within and Mental Hygiene. Ie marked other than sumatic avent, the Menmatic avent, the Menmatic avent, the Menmatic avent.		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Ma	iling Addres	s (Street a	and Numbe	r or Rura	Route Numbe	r, City or To	vn, State, Zip	Code)	
Σ	1 and 2 Health a tem 27 is		Bruce McIntire (1	nusband)	55 N	loon S	he11	DR,	Berli	n, MD	21811			
Baltimore,	S T = D		20a. Method of Disposition		20b. Place of Dis					ate		n - City or T	own, State	
Ĕ	Pages nent of int: if its iry or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Cape Her			1	3/13/	2007	Frankf	ord. I)E	
aĦ	permit. Page Department of Important: If any Injury or 9000		21. Signature of Funeral Service Licens	ee		22. Name a	nd Addres	s of Facility	The	Burbag	e Fune	ral Ho	ome	
B	odwi eny eny		I KM M	21/1/10						in, MD				
			23a. Part1. Enter the disease, or comp shock, or heart lailure. List only o	ications that caused	the death. Do not a	nter the mo	de ol dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Betw	reen
	Physician		Immediate Cause (Final disease or condition	5	icie.							į	Onset and D	eath
	/Medical		resulting in death)	aDue to (or as	a consequence of):									
	Examiner		Commentally lies and distance	b										
	D =	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):									
	nd nd trans	Examine	that initiated events	c										
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993	eath certific ettending pl	Med	IF FEMALE:											
Вох	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	B □Ectopic p						Date of delive Month		ear
o.	at the dea by the e	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	Other (s	pecify)					NOTE:	Day	5 0.
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Ö	w requir been si should	eted	The Stage	Selva Cu	sea se					141	A2 5 1140	3 1 100	Jably 4 Sol	KIIOWII
ec	e law has b	Completed								24a. Was a autop	sy	prior to co	opsy findings a impletion of ca	vailable use of
=		ပ္ပ								perfor 1 ☐ Yes	med? 2. No	death? 1 ☐ Yes	2□ No	
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	1			Ī o.		ol Death	Check only of	ne)			
of \	Physic this c	၉	TIL Tes 2/2/No	lospital:				4 🗆 190		e 5 Resid			(y)	
ñ		ő	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of fnju (Month, Da	ry 28b. Time y Year) Injur	/	28c. Injury Work			8d. Describe h	ow injury occ	curred		
Sic	Attending F ir death. ector: After by the funer	cat	Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М		res 2 1		0()		·		
Division of Vital Records,	of a strend efter death Director:	Certification;	4 ☐ Homicide determined	building, et	ury - At home, larm, c. (Specify)	street, lactor	ry, office		2	8f. Location (S City or Tow		mber or Run	al Houte Numb	er,
	pital urs e erai (20a Carifice Of Carolina Phil		Marie Land Land Company				a service to	and the second	oren marini u		LOW-OVI	
	Hoe 24 ho Fun fely f	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	ner: On the basis of	of my knowledge, da f examination and/or	investigation	n, in my op	ia, date an pinion, deat	th occurre	d at the time, o	late and plac	e, and due t	nated. o the cause(s)	
	To the Hospital or Att. within 24 hours effer de To the Funeral Directs completely filled in by the	Mec	29b. Signature and title of certifier	and manner sta	210U.	29	c. License	number			29d. Date sig	ned (Month	Day, Year)	
	E 2 4 8		1 Milton	M.D		1			112	0				
7			20 11-1) ' [_)		-10:::	1)	- (160		- 5/	19/0	000/	
	BA5		30. Name and address of person who co		eath (Item 23a) (Type 3 Heal H	e, Print)	11 An	1110	RA	rlin	MN	016	1.)	
	Sta	to.	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature		/	100	0	¥ [A # 1	: 1)	010		
1	Registr			007 King	un &	Conti	1							

			For State	State of N	Marylar		artment of F			- 1	2	007	nga	30
			Registrar 1. Decedent's Name (First, Middle	, Last)		- 00	Timeate of I	Death		2. Date of Dea	Reg. No ath	007	3. Time of De	eath U
Н	Physici /Media		Richar	d Lee Mil	1er	Sr.				Month March	Day	Year 2007	1:26	
	Examir		4a. Facility Name (If not institution			DI •	4b. City, Town, o	r Location o	of Death	naren	_	nty of Death		<u></u>
			Shady Grove Adv	entist Hosp	ital		Rockv				Mor	ntgome	ery	
	Funeral		5. Social Security Number	6. Sex 7 1 X M 2 ☐ F		last birthday)	If Under 1 Year Months Days	If Under	Min.	B. Date of Birt (Month, Day	y, Year)	9. Birth	place (State or Fo	oreign
ı.	Director		Usual Residence of Decedent		7	0 Yrs.			(Oct. 6	, 1936		yland	
	land ow t		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City L	_imits
	Mary -f sh ijed a	to	Maryland Montg	omerv		lockvi1	10						1 X Yes 2[□No
	h the	Director	10e. Street and Number	Omer y		COCKVII	10f. Zip Code				10g. Citizen o	of What Cou	ntry?	
	th wit 23a c ist be	alD	17 Paca Place				2085	2			Unit	ed St	ates	
	r dea	Funeral	11. Marital Status	12. Was Deceder Armed Force	s?		Was Decedent of H	lispanic Ori	igin? (Speci	ify Yes or No-		ace - Ameri lack, White,		
36	s afte , or it amin	y Fi	1 ☐ Never Married 2 ☒ Marri	If Yes, Give		5/-	1 ☐ Yes 2 🔀 No	Specify:		,	Spec		Cioi	
Ö	hour tural' al Ex	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent	Year or Dates	s: 19	160 0000	dent's Usual Occup	otion				Wh	ite	
7	in 72 n "na Nedic	olete	(Specify only highes	t grade completed)		(Give	kind of work done of DO NOT use retired	during most	t of working	,	16b. Kind of	Business/ir	dustry	
7	with jiene.	mo	Elementary/Secondary (0-12) 12	College (1-4c	or 5+)		Carpenter	,			Cons	truct	ion	
פַ	e filec al Hyg othel /ent,	Be C	17. Father's Name (First, Middle,	Last)					er's Name (First, Middle,	Maiden Surn			
/lar	uld by Menta Irked Itic ev	To E	Charles	Miller						Carrie	На	ger		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	•	19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mailii	ng Address (Street	and Numbe	er or Rural	Route Numbe	er, City or Tow	n, State, Zij	o Code)	
≥	and ealth m 27		Doris L. Miller	:/Wife_			aca Place	, Roc						
Ore	ges 1 t of H If itel		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from Sta		Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Dat	te	20c. Location	n - City or T	own, State	
altimore,	t. Pa tmen tant: jury		4 □ Donation 5 □ Other (Sp		Met		tan Crema			/2007	Alexar	ndria,	Virgin	ia
Ba	Depar Depar mpor any Ir	-	21. Si nature of Funeral Service I	icensee	10.		2. Name and Addres		Dev		neral H			
			23a Part1 Enter the disease or	complications that cause	od the deat		East Dee					ırg, M		7
-2			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.		er tile mode or dyin	J. J. A	Cardiac or	respiratory an	rest,		Approximate Interval Betwee Onset and Dear	
	Physician / /Medical		disease or condition resulting in death)	a Due to (or a		C/C T	My		VII					
9	Examiner			Due to (or a	as a conseq	quence or,.								
		ner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (ar s	es a ounsec	uanda uf):						- 8		
	cutec nd ransi	Examiner	that initiated events	c										
Ö,	e exe ian a urial-	Ĕ	resulting in death) Last	Due to (or a	as a conseq	uence of):								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d										
9 ×	leath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outcon	ne of pregn	ancy								
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant	2 🗆 Feta	al death 3	Ectopic pregnancy Other (specify)	1				Date of deliv Month	ery Day Yea	ır
o.	the d y the iched	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		icalii 5							:	
а.	uires that the de signed by the a Id be detached f	by Pi	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco use co	ntribute to t	he cause of deatl	h?
Records,	quires n sign	g p	atn	a fil	500	Cuttz				1 □ Y	es 2 Año	3 🗌 Pro	pably 4 □Unkr	nown
၀ွ	aw requir s been si 2 should b	Completed		4						24a. Was a	an 24b	o. Were auto	opsy findings avai	ilable
	sician; The law s certificate has b lirector, page 2 s	mo							·	autop	rmed?	prior to co death?	mpletion of cause	e of
Vital	lan; rtifica tor, p	BeC	25. Was case referred to medical	12				26. Place	of Death	│ 1□ Yes Check only or	2DHNo né≀	1 □ Yes	2□ No	
	nysic nis ce direc	일	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa	tient 2	ER/Outpatier	nt 3 DOA Othe	or:			lence 6 🗆 O	ther (Speci	fy)	
0	ding Physician; The n. After this certificate he funeral director, page		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury Day Year)	28b. Time o Injury	28c. Injun Work	y at k?	28	d. Describe h	ow injury occi	urred	,	
Sio	tendi eath. tor: A the fu	Satic	2 Accident investig	ation			M 1 1	Yes 2 ☐ l	No					
Division or	I or Atten after death Director: I in by the	Certification:	4 Homicide determi	ned 28e. Place of i building,	njury - At h etc. <i>(Specil</i>	ome, farm, str fy)	eet, factory, office		28	f. Location (S City or Tow	Street and Nur n, State)	nber or Run	al Route Number,	;
	pital ours a eral [29a. Certifier 19 Certifying	Bhysiology To the box	at of mucking	uvladaa daat	h occurred at the tim		4 -1	al alconomic				
	To the Hospital or Attending Physician; within 24 hours after deal. To the Funeral Director; After this certifica completely filled in by the funeral director; to the fune	Medical	(Check only 2 Medical s	g Physician: To the bes Examiner: On the basis and manner:	of examina	ation and/or in	vestigation, in my o	pinion, dea	id place, an ith occurred	d due to the d f at the time, d	cause(s) and i date and place	manner as s e, and due t	stated. o the cause(s)	
	o the	Me	29b. Signature and title of certifier	0 1			29c. License			2	29d. Date şigr	ned (Month,	Day, Year)	
			· Ill	uls	Market all .		5	42	508		N	lare	la 10,2	200
- (041		30. Name and address of person v		death (Iten	n 23a) (Type,	Print) D		>	1 1 2 2 5	1100	ico	unio	5
	= ===		C. CVV	uon, l	wy	ro	our	0	ru	NE M	401	de	N3208	52
	Sta Registr		31. Date filed (Month, Day, Year)	2007 32 Regis	strar's Signa	ature	wie				-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Marylan					-			00001
		1 - State Registrar		Ce	rtificat	te of Death	ל	F	leg. No.	UU /	09031
Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death
/Medic		GRACE	C. MAZZEI	LLI				MARCH	9,	2007	8:35 A M
Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City	, Town, or Location	of Death		4c. C	county of Deat	h
The state of a state o		NATIONAL LUTHER 5. Social Security Number 6. Sex	AN HOME 7. Age (In yrs.	last hirthday		ROCKVILLI	E or 24 Hrs.	8. Date of Birtl		MONTGOM	
Funeral Director			M 20XF 77	Yrs.	Months			AUG. 1	(, Year)		hplace (State or Foreign untry) RYLAND
pu ,		Usual Residence of Decedent	100 00	T							
lanyla shov	7	10a. State 10b. County		y, Town or Lo							10d. Inside City Limits 11 Yes 2 □ No
the N 28a-1	Director	MD. MONTGOME:	RY			VILLE p Code			10g Citize	en of What Co	
3a or	ā	9701 VEIRS DR.			101.21	20850			rog. Ott.	U.S.A	•
death ms 2	Funeral		2. Was Decedent Ever in U	.S. 13.	Was Dece	dent of Hispanic O cify Cuban, Mexica	rigin? (Sp	ecify Yes or No-	10	1. Race - Ame	rican Indian,
be filed within 72 hours after death with the Maryland the light with the Maryland that lygiene. and other than "natural", or items 23a or 28a-f show swent, the Madical Examiner must be notified at	y Fui	1 Never Married 2 Married	Armed Forces? 1			city Cuban, Mexica 2 ☑ No Specify		Hican, etc.)		Black, White Specify:	e, etc.
fural',	ed by	3 Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:			al Occupation				WE	ITE
in 72	Completed	(Specify only highest grade	completed)	(Give	kind of wo	nai Occupation ork done during mo ise retired)	st of work	ing	IDD. KIN	d of Business/	industry
lal y lallu Z 1 Z 1 Z 2 should be filed within and Mental Hygiene. Is marked other than aumatic svent, the Manager and the Man	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		SECR	ETARY				N.I.H.	
al Hys	Bec	17. Father's Name (First, Middle, Last)				18. Moth	her's Name	e (First, Middle,	Maiden S	'umame)	
should bind Ment	2	THEODORE	J. CLAYTON				A	MELIA	GI	RANT	
and rand		19a. fnformant's Name/Relationship (Typ			-	s (Street and Numb					
os 1 and 20 Health item 27 r other tr		GREG C. MATTES/		19108 Place of Dispo		JOHNSBUE		., GERM		VN, MD.	
Pages ment of mant: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, cre	matory or	other place)					
		21. Signature of Funeral Service License				MATORY nd Address of Faci		-2007		ERDALE,	
Dep name		WW Chan	.11.	00091	СНАМЬ 5801	nd Address of Faci EKS FUNE CLEVELANI	RAL H	OME & CI	KEMAT RDALF	TORIUM,	P.A. 20737
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that used the deat							1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	Approximate Interval Between
Physician		fmmediate Cause (Final disease or condition		205	, ,						Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):		infect					Imonth
LXailiniei	4	Sequentially list conditions, b.			ct	INTECT	120	\			The sould
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consec	uence or):							
be executed ician and burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							
- 6 % e	cai	d.									
ng ph	Medi	fF FEMALE:									
ath ce ttendi	an/I	23b. Was decedent pregnant in the past 12 months?	c. ff yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Idéath 3[∃Ectopic p	regnancy			23	d. Date of del	ivery Day Year
Attending Physicien: The law requires that the death certificate be executed at death. The thick that he has been signed by the attending physician and ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5[Other (s _i	pecify)				141011111	ouy .ou.
that the ed by	hd/	Part II. Other significant conditions cont	nbuting to death but not res	ulting in the u	inderlying o	cause given in Part	H.	23e. Did to	bacco us	e contribute to	the cause of death?
quires n sign	d by							1 🗆 Y	es 2	No 3□Pr	obably 4 Unknown
aw rec	Completed							24a. Was a		24b. Were au	topsy findings available
The late ha	шо							autop: perfor	med?	death?	completion of cause of
ien: ien: artifica ctor. p	Be C	25. Was case referred to medical examiner?		FR.59		26. Pfac	ce of Death	Check only or			20,10
hysic his ce	2	1 ☐ Yes 2 No	ospital: 1 Impatient 2	ER/Outpatie			lursing Ho	me 5 Resid	ence 6	Other (Spec	cify)
ding Physicien: The lav h. After this certificate has funeral director, page 2	iio	27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury at Work?		28d. Describe h	ow injury	occurred	
ttend death ctor: ,	cat	2 Accident investigation 3 □ Suicide 6 □ Could not be	28e. Place of fnjury - At ho	amo farm et	M factor	1 Yes 2		28f Location /S	troot and	Number of C	ıral Route Number,
atter atter Direct	Certification:	4 Homicide determined	building, etc. (Specif	y)	reet, lactor	y, office		City or Tow		INDITION OF THE	rai nobie Number,
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to		29a. Certifier 1 Certifying Physi	cian: To the best of my kno	wledge, deat	h occurred	at the time, date a	ind place,	and due to the o	ause(s) a	nd manner as	stated.
the Ho in 24 he Fu pletel	ledical	(Check only 2 Medical Examinations)	er: On the basis of examina and manner stated.	tion and/or in	vestigation	n, in my opinion, de	ath occurr	ed at the time, o	late and p	lace, and due	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	10-11			c. License number		à	9d. Date	signed (Montl	n, Day, Year)
6		Same	I muller			200206	15	İ	narc	h 9,	2007
		30. Name and address of person who con				יים מיים	7 77 777	e Ma	20050		
Sta	te	SAMUEL G. MALLI 31. Date filed (Month, Day, Year)	ER, M.D. 9	ture		DR., ROCK	VLLL.	E, MD.	۷۵۵(,	
Registr		MAR 1 3 2007	Alane d	K Ch	astil						

			For State Registrar	State	of Mary		artment of I rtificate of		Mental H	ygiene Reg. No.	0000	
3	Dharis		Decedent's Name (First, Middle	e, Last)					2. Date of D		2007	3. Time of Death
1	Physici /Medi		PHYLLIS				NEWMAN		03/11		Year	8:05 a M
	Examir	ıer	4a. Facility Name (If not institution	. •	umber)			or Location of De		4c. (County of Death	
-		400	5108 RUSSETT RO 5. Social Security Number	AD 6. Sex	7 Age (In	yrs. last birthday)	R If Under 1 Year	OCKVILLE If Under 24 H		lirth		TGOMERY place (State or Foreign
	Funeral Director		075-26-7911	1 □ M 2 🔀 F		75 Yrs.	Months Days	Hours Mi		Day, Year)	Con	ntry) PA
			Usual Residence of Decedent									
	anylar show	-	10a. State 10b. County		100	. City, Town or Lo	ocation				1	10d. Inside City Limits 1 XYes 2 No
	the M 28a-f notifie	ecto	MARYLAND MO 10e. Street and Number	NTGOMERY			10f. Zip Code	ROCKVI	LLE	10a Citiz	en of What Cou	
	3a or	D	5108 RUSSETT RO	AD			Tot. Zip Code	20853		Tog. Citiz	USA	nuy:
	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was De Armed F	cedent Ever	in U.S. 13.	Was Decedent of I If Yes, specify Cub		(Specify Yes or N	10- 1	4. Race - Americ	
9	or ite		1 Never Married 2 Marr	ied 1 ☐ Yes	2 🔼 No		1 ☐ Yes 2X No		erto Hican, etc.)		Black, White, Specify:	etc. WHITE
21215-0036	hours tural"; al Exe	d by	3 ☑ Widowed 4 ☐ Divorced	Year or	Dates:			, ,				
2	in 72 "na" r	Completed	(Specify only highe			(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wed)	vorking	16b. Kin	id of Business/In	dustry
2	d with giene. r thar	mo.	Elementary/Secondary (0-12)	1	(1-4or 5+) 4	l l	ER'S ASS	-			PUBLTC	SCHOOLS
	0 = 0 5	BeC	17. Father's Name (First, Middle,	Last)					ame (First, Middi	le, Maiden S		Волооны
<u>X</u> a		안	CLIFFORD FAGIN					ROSE (
Maryland	au is		19a. Informant's Name/Relations STACY F. NEWMAN		D		ng Address <i>(Street</i>					
	1 an Heal em 2 ther		20a. Method of Disposition	T/ DAUGHTE.		Ob. Place of Dispo	HAWTHORN	E SIKEEI	Date		ARY LAND	
Baltimore,	9		1 ☑ Burial 2 ☐ Cremation		n State	cemetery, cre	matory or other pla			1	/	
≣	permit. Pag Department Important: any injury c		4 ☐ Donation 5 ☐ Other (S		J		MORIAL G		13/2007		EY, MARY	
ñ	perr Dep Imp any		1 CHANN			D	Name and Addre ANZANSKY 170 ROCK	-GOLDBER	RG MEMOR	IAL CH	HAPELS,	INC. AND 20852
8/60,	Physician /Medical Examiner the prival-transit	al Examiner	23a. Parkt. Enter the disease, or shock, or hear failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. META Due to b Due to	ASTATION (or as a con	C BREAST isequence of:		ng, such as card	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
.O. Box 68/	the death certifi y the attending iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	birth 2 □ I gnant at time nown	Fetal death 3 C of death 5 C	Ectopic pregnanc Other (specify)			23	3d. Date of delive	ery Day Year
rds, -	requires that een signed b nould be deta	5	Part II. Other significant condition	ons contributing to	death but not	resulting in the u	nderlying cause giv	en in Part I.				ne cause of death? Dably 4 □Unknown
II Hecord	The la ate has page 2	Completed							per	s an opsy tormed? 2 12 No	24b. Were auto prior to co death? 1 ∐ Yes	ppsy findings available mpletion of cause of 2 ☐ No
VITal	Physician: this certific	Be (25. Was case referred to medical examiner?	-			l au		eath Check only			
0	Phys this aral dir	2	1 ☐ Yes 2 ☐XNo 27. Manner of Death	Hospital: 1 _		2 ER/Outpatier		4 Li Nursing	Home 5 Res			y)
SION	Attending Phys r death. ector: After this by the funeral dir	ation	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Mo jation	nth, Day Yea	r) lnjury	Wo	ryat rk? Yes 2∐No	28d. Describe	how injury	occurred	
2	tal or Att s after d al Direct ed in by	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined Zoe. Plac	e of Injury - A ding, etc. <i>(Sp</i>	At home, farm, str ecify)	eet, factory, office		28f. Location City or To	(Street and own, State)	Number or Rura	al Route Number,
	To the Hospital or Attending Physician: whim 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 ☑ Certifyin (Check only one)	g Physician: To th Examiner: On the and ma	e best of my basis of exam nner stated.	knowledge, deatl nination and/or in	occurred at the tivestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) a e, date and p	and manner as s place, and due to	tated. o the cause(s)
	To the Vithii Comp	ž	29b. Signature and title of certifier	(1)	0	6-	29c. Licens				signed (Month,	
	10		Buener	evina	Kai	55 m		064615		MARCI	H 12, 20	007
	io .		30. Name and address of person GENEVIEVE WROBI				Print) RD DR, SU	ITE 100	, ROCKVI	LLE, N	MARYLAND	20850
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1	2007	gistrar's S		neutre)				· · · · · · · · · · · · · · · · · · ·	

		1 - State Registrar			rtificate of			Reg. No.	7.09833
Physic /Med		1. Decedent's Name (First, Middle, Last) Viola Tere	sa Nic	holson			2. Date of Dea Month March	Day Ye 13 200	
Exami		4a. Facility Name (If not institution, give s Calvert County Nu:		er		r Location of Death Frederic	1	4c. County of D	eath
Funera Director		379-09-5029	M 2XF 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day July 1		Birthplace (State or Foreig Country) ashington, D
h the Maryland r 28a-f show r notified at	irector	Usual Residence of Decedent 10a. State 10b. County MD Calver 10e. Street and Number		c. City, Town or Lo	rederic	ζ		10g. Citizen of What	10d. Inside City Limits 1 □ Yes 2 □ No Country?
be filed within 72 hours after death with the Maryland tital Hyglene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	2. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	16a, Dece	206 Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2☐ No dent's Usual Occup	ispanic Origin? (Sj an, Mexican, Puert Specify:		United S 14. Race - A Black, W Specify: 16b. Kind of Busine	merican Indian, /hite, etc. white
	Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 0 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		kind of work done DO NOT use retired Ceutical	compound	ler	pharmace	utical
should and Mer s marke	To B	George W. Chaney 19a. Informant's Name/Relationship (Type						Norton er, City or Town, Stat	
Pages 1 and 2 nent of Health ant: If item 27 I ury or other tra		Eldred W. Nicholso 20a. Method of Disposition 1 M Burial 2 Cremation 3 Re	emoval from State	0b. Place of Dispo cemetery, cres	sition (Name of matory or other plac	ce)	Date	Leonard,	or Town, State
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22	rial Gard 2. Name and Addre Rausch Fu	ss of Facility		Dunkirk, Owings, M	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and position of the funeral director, page 2 should be detached for use as the burial-transit of the burial control of the burial contr	ledical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a cor	nsequence of):	er the mode of dyin	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
equires that en signed b	þ	Part II. Other significant conditions con	4	t resulting in the ur	nderlying cause give	en in Part I.	23e. Did to		e to the cause of death? Probably 4 ∐Unknow
n: The law re ficate has be r, page 2 sho	Completed							sy prior rmed? death 2MNo 1□1	e autopsy findings availabl to completion of cause of i? 'es 2 □ No
/sicia s certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe	26. Place of Dea		<i>ne)</i> lence 6 □Other (S	
ath. or: After thi	ation: To	27. Manner of Death 12 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Injur Worl	y at		ow injury occurred	peuly)
Ital or Atters of safers of sal Director led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (Sp	At home, farm, stropecify)	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	(Check only 2 Medical Examin	ician: To the best of my er: On the basis of exa and manner stated.	/ knowledge, death mination and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and place, and	due to the cause(s)
Mith	Z	29b. Signature and title of certifier		MD		0370		3/ /4/6	
<i>5</i>	ate	30. Name and address of person who cor Peter L. Wisni 31. Date filed (Month, Day, Year)	ewski M.	D. 110	<i>'</i>		l Suite	310 Pr	ince Frede

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Department of Health and M Certificate of Death	-	giene Reg. No. 🔿 🔘 🤭	00001
	35	17	1. Decedent's Name (First, Middle, Last)	2. Date of De	ath 4 UU	3. Time of Death
в	Physici		Sharon M. Newnam	March	7 2007	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	riai cii	4c. County of Dea	
			Atlantic General Hospital Berlin		Worceste	ar
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bird (Month, Da		rthplace (State or Foreign ountry)
	Director		215-72-2895 1 M 2 K F 42 Yrs. Months Days Hours Min.	Jan. 5	, 1965 N	MD
	pu ,		Usual Residence of Decedent			
	arylai show d at	.	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ne Ma 8a-f	5	MD Worcester Snow Hill		·	1XXYes 2 □ No
	with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	ath w		111 Purnell St. 21863		USA	
	er de tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Am Black, Whi	
36	s aft	by F	1 ☐ Never Married		Specify:Whi	te
15-0036	be filed within 72 hours after death with the Maryland ttal Hyglene. In a water a sa or 28a f show dother than "natural", or items 23a or 28a f show event, the Medical Examiner must be notified at	ed k	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	/Industry
5	in 72 n "na Medic	plet	(Specify only highest grade completed) (Give kind of work done during most of working tife DO NOT use retired)	ng	Too. Tana of Baomood	maddiy
7	with jiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Unemployed		None	
<u>0</u>	filed Hyg other ent,	Be C		(First, Middle,	Maiden Surname)	
<u>8</u>	lld be lenta ked ic ev	To B	Richard Mitchell Janet Wa	tson		
Maryland 21	shound N	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura	al Route Numb	er, City or Town, State,	Zip Code)
	and 2 alth a 27 is		Charles Edward Newnam (husband) 111 Purnell St., Snow	Hill, 1	Md. 21863	
Baltimore,	ages 1 and 2 should be filed went of Health and Mental Hygier It: If Item 27 is marked other thy or other traumatic event, the	18	compteny cromatony or other place)	ate	20c. Location - City of	Town, State
Ĕ	Pages nent of l int: If it	11	1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bates Cemetery 3-12-	2007	Snow Hill,	Md.
픮	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility The			
ñ	an la la la la la la la la la la la la la	ji di	W. Gut Suches 108 William St., Be	erlin. I	Md. 21811	Trome
T			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician	e j	Immediate Cause (Final			Onset and Death
	/Medical		disease or condition resulting in death) a. SEPS1S Due to (or as a consequence of):			-
	Examiner					
	TO THE	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Literate or injury that initiated events.			
	cutec nd ransit	Examiner	Caus of Closade or Injury that initiated events C			
Ď,	an ar	EX	resulting in death) Last Due to (or as a consequence of):			
68/6 0,	icate be executed physician and s the burial-transit	edical	d			
	ng ph	Med	IF FEMALE:			
Š Q	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	hysician/M	23b. Was decedent pregnant 23c. If yes, outcome pt pregnancy		23d. Date of de	
	e dea he at ed fo	sici	1 ☐ Yes 2 📶 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
J.	at the	Phy	9 Li Unknown	17		
<u>'</u>	res th igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute t	
ecords,	requi	ted	End stage renal disease	, , ,	res 2 No 3 P	robably 4 Unknown
ပ္	~ Q to	Completed	<u>Diabetes</u>	24a. Was		utopsy findings available completion of cause of
I =	The law	50			rmed? death? 2√□ No 1 □ Yes	·
V Ital	Physician: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?	(Check only o		
5	hysic his call	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	me 5 🗆 Resid	dence 6 □Other (Spe	ecify)
	ding Physin. h. After this continues of the continues of	:io	1 DXNatural 5 Pending (Month, Day Year) Injury Work?	28d. Describe h	now injury occurred	
DIVISION	tend eath. tor: / the fi	cati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 288 Place of injury. At home farm street featons office			
≥	or At fter d Sirect in by	Certification:	4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tov	Street and Number or Fi vn, State)	ural Route Number,
	urs a	ပ္ပ				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, a constant of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ed at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	the thin 3 the mple	Med	and manner stated. 29b. Signature and stitle of certifier 29c. License number		29d. Date signed (Mon	th Day Year)
	F 2 F 8	-	11/4-3	I .	03/13/	200.
ı			11/20		-3/13/	200/
	BA3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AG Id 9733 Health way drive Berlin MD 21	811		
, "	Sta	te.	31. Date filed (Month, Day, Year) 32 Megistrar's Signature	- 1 /		
	Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A G Id 9733 Health way arrive Berlin MI) 21 31. Date filed (Month, Day, Year) MAR 1 3 2007 MAR 1 3 2007			

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			For State	State o	f Marylan						0.0	5 375 6007	0000
			State Registrar			Cei	tificate o	ot Death	7		eg. No.		09835
	Physici	an	Decedent's Name (First, Middle, Robert I	Velson						2. Date of Dea Month	Day	Year	3. Time of Death 5.50PM
	/Medio		4a. Facility Name (If not institution,		mber)		4b. City, Tow	vn, or Location	of Death	MARCIT		y of Death	37301
	Examir	ier	Doctors Comm	-				anham			Pri	nce G	eorges
	Funeral		5. Social Security Number	3. Sex	7. Age (In yrs. I		If Under 1 Y	ear If Unde	r 24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign
- 8	Director		579-48-1494	1⊠M 2□F	70	Yrs.				July 22			n Carolina
	and and		Usual Residence of Decedent 10a. State 10b. County			, Town or Lo		-				1	0d. Inside City Limits
	Maryl f sho	ō	MD Prince	Georges		Lanham							1 AYes 2 No
	r 28a	Director	10e. Street and Number			-	10f. Zip Co	de		1	10g. Citizen of		
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	a D	6519 Westview	Lane				20706			Unit	ed St	ates
	r dea tems er mu	Funeral	11. Marital Status	Armed Fo		S. 13.\	Nas Decedent f Yes, specify	of Hispanic O Cuban, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🏻 Widowed 4 ☐ Divorced	d 1 Yes If Yes, Giv	² □No ve 1954 ^{ates:} 1956	_ 1	1 □ Yes 2 %	No Specify	<i>/</i> :		Speci	_{fy:} Bla	ck
Ş	2 hour aturai cal Ex	pe	15. Decedent's	Education	1956	16a. Deced	dent's Usual O	ccupation		-1	6b. Kind of Business/Industry		
7215	within 72 iene. than "nai the Medic	Completed	(Specify only highest	grade completed) College (1	1-4or 5+)	(Give life. l	kind of work do	etired)		ing	G	-16	
35	filed wit Hygien other the	S	Elementary/Secondary (0-12)				Seli	Employe				elf	
バモLSON, ROBSUT Baltimore, Maryland 21215-0036	d tal	Be	17. Father's Name (<i>First, Middle, L</i> Robert	_{ast)} Nelson				18. Moth		e (First, Middle, y Ellen			
1 × 2	2 should and Men is markeraumatic	은	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	na Address (St	reet and Numi	ber or Run	al Route Numbe	r. City or Town	n. State. Zir	Code)
5, ₹	and 2 s ealth ar n 27 is er trau		Debbie Lee Wi		laughter					District			
ELSON, more, N	s 1 a of Hea item		20a. Method of Disposition	0 CD		lace of Dispo emetery, crer	sition (Name o	of r place)	[Date	20c. Location	- City or To	own, State
EL imo	Page ant: if ury o	1弦 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln 3/16/2007 Brents 21. Signature afficured Service Licensee 22. Name and Address of Facility McGuire Funeral											
≥ 3alt	permit. Page Department of Important: if any Injury or once.		21. Signature of Funeral Service L	icensee									ce, Inc. DC 20012
		Н	23a. Part1. Enter the disease, or o	Mays	sound the death							9 2011	Approximate
			shock, or heart failure. List o	inly one cause on e	each line.	_							Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a Due to	(or as a consequ		2791	Simo	wap	ww		-	
0	Examiner			, 4	Awre	,	lmonu						
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consequ	uence of):	5	0					
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):										
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687	ficate g physics the l	edical		d							\$		
Вох	h certi	m/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome pf pregna	incy	Ectopic pregn	anov				ate of deliv	*
	w requires that the death certific been signed by the attending f should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (specif				M	lonth	Day Year
P.0	d by the	Phy	9 ☐ Unknown Part II. Other significant condition	as contributing to d	eath but not resu	ulting in the u	nderlying caus	e given in Part	H	23e Did to	hacco use cor	atribute to t	he cause of death?
ds,	signe d be c	d by	· Historia d P	Ilmanux		beles		T (Do	0.0	1 🗆 Y		3 ☐ Prol	1
Ö		lete(Wein thro	mboses	10 6	75Hm	^	Makel a	Chacal	24a. Was a	an 24h	Were auto	ppsy findings available
Re	sician: The law r s certificate has be lirector, page 2 sh	Completed by	Cl and shall	11100300	Palassa		iseen	- Lbin	ertensi	autop	med?	prior to co death?	mpletion of cause of 2 ☐ No
ita	ian: rtifica tor, p	BeC	25. Was case referred to medical	rachive	Tulmor	iary i	1steer C			n 1□ Yes h (Check only o	ne)	1 1 1 63	ZENO
> -	hysic his ce I direc	ToE	examiner? 1 Yes 2 No	Hospital: 1	inpatient 2	ER/Outpatier			Nursing Ho	me 5 Resid	ence 6 🗆 O	ther (Speci	(y)
Division or Vital Records,	Ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe h	ow injury occu	irred	
isio	death ctor: y the f	icat	2 Accident investigation 3 Suicide 6 Could not determine	ot be 280 Place	of injury - At ho	me, farm, str	M eet, factory, of	1 ☐ Yes 2 ☐		28f. Location (S	treet and Num	ber or Run	al Route Number,
Οį	al or A after I Dire	Certification:	4 ☐ Homicide determin	build	ing, etc. (Specify	v)				City or Tow			
	lospit hours unera			Physician: To the									
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	one) 29b. Signature and title of certifier	and man	ner stated.			icense number			29d. Date sign		
			255. Signature and little of Certifler					F84	-		1 -)
	3		30. Name and address of person v	who completed caus	se of death (Item	1 23a) (Type		107	TOU	77	3/2	10 -	<u> </u>
			Slisap=	+11 F	TISIK	Δ.		MIN ST	KEE T	- 50178	357	LAURE	4, MO 20707
	Sta Regist		31. Date filed (Month, Day, Year)		egistrar's Signa	ture	acts F						

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AMEND TTFM#19b perFH G865 3/28/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22, **Physician** MARCH 2007 09:35FM HATTIE PAUL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 220-09-0558 85 June 9. Director Maryland Usual Residence of Decedent ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No Director Baltimore MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 4721 Hazelwood Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify. Completed by White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giese Paul Albert Kunigunda Kalb ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21015 19a. Informant's Name/Relationship (Type. Print) permit, Pages 1 and 2:
Department of Health as Important: If item 27 Is any injury or other trau Joan Moxley/Daughter 2518 Fairway Drive Bel Air, Md. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cremation 3/24/07 | Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Çarroll 21. Signature of Funeral Service Like see 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Immediate Cause (Final **Physician** disease or condition resulting in death) END-STAGE PULMONARY FIBROSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760, attending physician and for use as the burial-trar The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No - 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 18 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ∏Yes 2 ∏No 2 Accident 3☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

W State 29b. Signature and title of certifier

ABDALLAH J. HE
31. Date filed (Month, Day, Year)

MAR 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 ande

7601

29c. License number

DØØ17695

OSLER DRIVE TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year JOHN NORMAN PARATER **Physician** PARATER AKA 6:20 PM MHOL MARCH 2007 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE NIA UNIVERSITY OF MARYLAND MEDICAL CONTE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 220-28-6428 5, Washington, Sept. 1934 DC Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or Items 23a or 28a-f show r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a or 15003 Peachstone Drive Funeral 20905 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 9 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked John Henry Parater Gwendolyn Louise Ellin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Important: If item 27 is any Injury or other trau Mary Lee Parater/ Wife 15003 Peachstone Drive, Silver Spring, MD 209 5 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 14, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. Joh Kyle Colles 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CIRRHOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

Records, P.O. Division or Vital

State Registrar

22 UMMC 31. Date filed (Month, Day, Year) NAR 1 4 2007

AND ROW SERSOH

29b. Signature and title of certifier



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. GREENE



BALTIMORE

29c. License number

17410

ANDREW DORSCH

29d. Date signed (Month, Day, Year)

, MD

21201

MARCH 12, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra AMEND#28 fiper ME3/14/07, EMW, MoCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2007 Richard Dayne Persaud March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6615 61st Place Riverdale Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 27, 1970 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1**∑** M 2□ F 36 158-80-4645 Guyana Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Medical Examiner must be notified at Riverdale Maryland Prince George's 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 20737 United States 6615 61st Place death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, With St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 0 Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Yes, Give ear or Dates: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Department of Health and Mental Hygiene in Important: If item 27 is marked other than in any Injury or other traumatic event, the Me once. College (1-4or 5+) Manager Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Persaud Molly Yhap Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6615 61st Place Riverdale, Maryland 20737 19a. Informant's Name/Relationship (Type. Print) Babita Persaud -wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD National Mem. Park 3/12/2007 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Horald Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) As oh x : a ton Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊟ Yes 2□ No 2 within 24 hours after death.

To the Funeral Director: After this 28d. Describe how injury occurred WAAPAA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Mar 28 250 | Giry M | 1 | 28e. Place of indury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Bural Route NumPlace Richard State) 6/3 4 ☐ Homicide home 1 ☐ CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Chave 3001

State Registrar 31. Date filed (Month, Day,

Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 12:05 P M MARCH 9, 2007 SHEILA RUTH KOTKIN PAPER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. MAY 4, 1943 Days Hours 1□M 2 🖺 F WASHINGTON, DC Director 578-54-2763 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show int or other traumatic event, the Medical Examiner must be notified at MARYLAND GAITHERSBURG MONTGOMERY 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14912 POMQUAY COURT USA 20878-2539 Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) RESIDENTIAL REALTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GERTRUDE ABBOTT MAX KOTKIN ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14912 POMQUAY COURT, GAITHERSBURG, MARYLAND MICHAEL PAPER/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c Important: If any Injury or once. GARDEN OF REMEMBRANCE 03/11/2007 CLARKSBURG, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 21. Signature of Funeral Service Licensee enous 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed burial-trar and Due to (or as a consequence of) physician s the burial Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð No 3 ☐ Probably 4 ☐ Unknown 1 Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s cate h Yes 25. Was case refe d to medical examiner? funeral director 26 Place of Death (Check only one Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital P 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of each 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No hours a er death. 2 ☐ Accident within 24 hours a er death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Gold

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-15

2007 4

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Vital

0

Division

2

40

29c. License number

* Rocky

07-01928 Louis Prahl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

iis Prani		State of Maryland / Departi- For State Certi	tment of Health and Menta ificate of Death	an myglene Reg. l	No. 2007 0001
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
dical Exami		LOUIS C. PRAHL	4b. City, Town, or Location of	March 11, 20	1623 FITS 4c. County of Death
		4a. Facility Name (if not institution, give street and number) Dorchester General Hospital	Cambridge	Death	Dorchester
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las			MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		218-40-5645 1XM 2_F 63	Yrs. Months Days Hours	APRIL 1,	1943 Country) MD
any	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Location		10d. Inside City Limits
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farylar	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
vith the Maryland s 23a or 28a-f show s e notified at once.		3036 STEAMER RUN ROAD	21613		USA
th with	Funeral	11. Marital Status 1 Never Married 2 Married 2 Armed Forces? 1 Yes 2 No	 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican, 		 Race - American Indian, Black, White, etc.
er dea		1 Yes 2 No 3 XWidowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: WHITE
Murs afi Itural' aming	d by	or Dates:	16a. Decedent's Usual Occupation (Give k		6b. Kind of Business/Industry
6 172 hc an "ns cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		ise retired)	PLUMBING
5-0036 led within 7. Hygiene. I other than the Medical	omp	12 0 17. Father's Name (First, Middle, Last)	PIPE-FITTER	s Name (First, Middle, Ma	
115-	Be C	GEORGE A. PRAHL		ARGARET L. (
2121 ould be fill Mental F marked ic event,	To E	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Num		
MD d 2 sh llth and n 27 is aumat		KATHY J. HUMPHRIES/NIECE	4251 OSBORNE ROA		MD 21643 20c. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 Removal from State	lace of Disposition (Name of cemetery, rematory or other place)		•
time E. Page tment rant:		4 Donation 5 Other Specify:	FORD CEMETERY	3/16/2007	OXFORD, MARYLAND
Bal permit Depar Impo		21. Signature of Funeral Service Licensee	FELLOWS, HELFEN	BEIN & NEWNA	AM FUNERAL HOME PA MD 21601
Physician		23a. Part I. Enter the disease, or complications that caused the death.	Do not enter the mode of dying, such as ca	ardiac or respiratory arres	t, shock, or heart Approximate Interval Between Onset and
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. xanımer		or condition resulting in death) Due to (or as a consequence of):		
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
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ited d ansit	Exa	events resulting in death) Last Due to (or as a consequence of d.	<i>p</i> -		
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - trans	8	IF FEMALE: 23c. If yes, outcome of pregr 23b. Was decedent pregnant in the		a managana y	23d. Date of delivery Month Day Year
Box 687 death certific he attending p	cian	past 12 months?	2 Fetal death 3 Ectopic 5 Other (Specify)	pregnancy	l violiti bay
Box e death the atte	Physician/	1 Yes 2 No 9 Unknown 9 death Unknown			Library to the course of double?
P.O. ss that the igned by be detach	by P	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Pa		acco use contribute to the cause of death? 2 No 3 Probably 4 V Unknown
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Sord law rethas be 2 shor	Completed			autops perform	ned? death?
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Tital sician is certi lirectol	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other		Residence 6 Other:
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	을 ::	1 ✓ Yes 2 No Pattern 2 ✓ 27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work	? 28d. Describe ho	ow injury occurred
ion tendin eath. tor: A	atio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2		
Division tal or Attendir rs after death. al Director: /	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At ho	ome, farm, street, factory, office building, e	tc. 28f. Location (St or Town, St	treet and Number or Rural Route Number, Cit ate)
D sspital hours meral y filled	Se	4 Homicide determined (Specify) 29a. Certifier 1 Continue Physician: To the best of my knowledge		and due to the squee	(c) and manner as stated
the Ho nin 24 the Fu	Medical	(Check only one) 2 ✓ Medical Examiner: On the basis of examination a	ge, death occurred at the time, date and pl nd/or investigation, in my opinion, death oc	ccurred at the time, date a	and place, and due to the cause(s)
To To To com	Med	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		10-6-411ATTS	O.C.M.E.	ŀ	March 12, 2007
- 142		30. Name and address of person who completed cause of death (Item			
5NA	7	Zabiullah Ali, M.D. Assistant Medical Examiner		MD 21201	
S Regis	tate	1180 4 0007	ure		
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		ш	Decedent's Name (First, Middle	e, Last)							2. Date of De	eath	6-3-1	3. Time of Death
	Physici /Medic		DONNA PETER	SON							Month O3	04	y Year 2007	6:40 P ^M
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	× 10		LAUREL REGI					AURE						EORGE'S
	Funeral		5. Social Security Number	6. Sex 1 ☐ M ②CX F	7. Age (In yrs. I	Ven	If Under Months	Days	If Under Hours	Min.	8. Date of Bi	ay, Yea <i>r)</i>) 0	rthplace (State or Foreign Country)
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d 21215-0036 filed within 72 hours after death with the Maryland	nt of Health and Mental Hyglene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2∑ Mari 3 □ Widowed 4 □ Divorced	ied Armed Fo 1 ☐ Yes If Yes, Giv	2 X No re		Was Deced If Yes, spec 1 ☐ Yes 2				ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Wh Specify: BL	ite, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours af	atura cal E	bed	15. Deceden	t's Education			dent's Usua					16b. K	and of Business	s/Industry
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altimore,	Department Important: I any injury o	1	4 □ Donation 5 □ Other (S 21. Signature of Funeral Service					d Addre	MARESCHI					MD, INC.
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8 4	40 40		23a. Art1. Enter the disease, or hock, or heart failure. List	complications that conty one cause on e	aused the death	n. Do not ent	er the mod							Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition		ASPIRAT	ION PN	EUMON	TA						Onset and Death
The same of	Medical		resulting in death)	_a.	or as a consequ									
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68 tifficat	g physi as the t	edic		0.										
Box eath cert	attending pl	M/M	IF FEMALE: 23b. Was decedent pregnant		come pf pregnai		Tetoniana						23d. Date of de	elivery
ig o	been signed by the atte should be detached for	Physician/Me	in the past 12 months? 1 □ Yes 2 🛣 No 9 □ Unknown		ant at time of de		Ectopic pro Other (sp						Month	Day Year
S, P	gned l	by P	Part II. Other significant condition		ath but not resu	Iting in the u	nderlying ca	ause give	en in Part I	i.	23e. Did	tobacco i	use contribute t	to the cause of death?
oduir.	en si	led	DECUBIT	JS ULCERS							10	Yes 2	Mo 3□ P	Probably 4 ☐Unknown
Vital Records, sician: The law requires to	as be	Completed	MULTIPL	E URINARY	TRACT	INFECT	IONS				24a. Was		24b. Were a	utopsy findings available completion of cause of
	cate has l	Con									perfo 1∐ Yes	ormed? 2⊡ No	death?	`_
VICIAN	certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:				T _{O4} b		of Death	(Check only	one)		
Phys	this al di	<u>٩</u>	1 Yes 2 No 27. Manner of Death	28a. Date o		ER/Outpatier			4 🗆 Nu				6 □Other (Spe	ecify)
on gulb	n. After funer	ë	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Mont	h, Day Year)	Injury	м	8c. Injury Work 1 □ \	(? Yes 2 🔲 .		28d. Describe	now inju	ry occurred	
DIVISION OF	irector:	Certification:	3 Suicide 6 Could	not be 28e. Place	of injury - At hor	me, farm, str	eet, factory		_	-	28f. Location (Street ar	nd Number or F	Rural Route Number,
اة الله الله الله الله الله الله الله ال	rs arre	enti	4 ☐ Homicide determ	buildir	ng, etc. (Specify	"					City or To	wn, State	e)	
ospit	E ≡ E		29a. Certifier 1 Certifyir (Check only 2 Medical	g Physician: To the Examiner: On the ba	best of my know	viedge, deat	occurred a	at the tim	ne, date an	nd place,	and due to the	cause(s) and manner a	is stated.
	within 24 he To the Fur completely	fedical	one)	and mann	er stated.	on anu/or m				atti occur	eu at the time			
2	L COU	Σ	29b. Signature and title of certifie	Var.	100	1111		. License					te signed (Mon	
	8		- SOTTIN	a MM	WS,	111		מטטע	1586			03	-06-200	
LI	14/		30. Name and address of person	9				107	T A ***	יים	MD 007	0.7		
	Sta	te_	TIFFANY SANDE	32. R	+44U CHI egistrar's Signat	urga _	ANE #	104,	LAUI	KEL,	MD 207	0/		
	Registr		MAR 1 4 2007	harm	egistrar's Signat	forth	•							

		1 - For Stata Ragistrar	Type or Prir State of Ma		l / Depa		of H	ealth and M	lental Hy		2007	09842
Physicia /Medic		Decedent's Name (First, Middle, Lass RUTH EDITH H	PARKNOW						2. Date of De Month 03-08	Day		3. Time of Death
Examine Funeral Director		4a. Facility Name (If not institution, give ANNE ARUNDEL MED 5. Social Security Number 6. S 578–58–4662	CAL CENTE	R e (In yrs. /a:	st birthday) Yrs.	Annap	0 1 i	Location of Death S If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	An	ne Arun 9. Bin Linc	
A ^e		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation			02-22-	1929		10d. Inside City Limit
the Marylar 28e-f ehow	Director	Maryland Anne Arus	ndel		Arno	1d	ode			10a. Citi	zen of What Co	1 🖟 es 2 🗆 N
eath with		305 College Parky	Nay	Ever in U.S.	13.1		21	012	acify Yas or No	U	SA 14. Race - Ame	
within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23a or 28e-f ehow he Madical Exeminer must be notified at	by Funeral	1- Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Agned Forces? 1 ∰Yes 2 ☐ I If Yes, Give Year or Dates:			f Yes, specify 1. Baryes 2. □		spanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)		Black, Whit	
d within 72 ho piene. r than "natur ine Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)		5+)	(Give life. l	dent's Usual (kind of work DO NOT use ekeepi	done d retired	ation furing most of worki)	ing		nd of Business	
be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last) Jacob Parknow			11045	evecht	.ng	18. Mother's Name		Maiden	Sumame)	
hould id Men marke matic	2	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	na Address (S	Street a	Ida Fri		er. City o	Town, State.	Zip Code)
nd 2 salth an 27 is i		Edward H. Schart		n				Lane G1		-		
permit. Pages 1 and 2 s Department of Health ar Important; if I tem 27 is any injury or other trau once.		20a. Method of Disposition † Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control of		cer	ace of Dispo metery, crer	sition (Name natory or othe 11 Cem	of er plac	θ)	Date	20c. Lo	cation - City or	Town, State
rmit. F spartmi porter y Injui		21. Signature of Funeral Service Licer			22	. Name and	Addres	ss of Facility				Md. 20746
	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Septic S Due to (or as b. UTI Due to (or as c. Diabetes Due to (or as	a conseque	ence of):							Onset and Death
the death certificate by the attending phy: ached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal	death 3	Ectopic preg				4	23d. Date of de Month	livery Day Year
w requires tha been signed should be det	Ď	Part II. Other significant conditions of	ontributing to death b	ut not resul	lting in the u	nderlying cau	ise give	en in Part I.		obacco u Yes 2[o the cause of death? robably 4 🙀Unknow
	Completed								24a. Was auto perfo 1 \(\text{Yes}	psy ormed?	prior to death?	utopsy findings availab completion of cause of 2 No
Hospital or Attending Physician: The la 14 hours after death. Funeral Director: After this certificate has tely filled in by the funeral director, page 2	ation: To Be	25. Was case referred to medicat examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 個 Inpatie 28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o Injury		. Injun	4 Nursing 110		dence (icity)
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of In	jury - At hor c. (Specify)	me, farm, str	reet, factory, o	office		28t. Location (City or To			ural Route Number,
To the Hospil within 24 hour To the Funer completely fill	edical		niner: On the best and manner st	f examination						date and	place, and due	e to the cause(s)
To the within 2 To the complet	×	29b. Signature and title of certifier	Helm	1		29c. I	Licens	2143	8		e signed (Moni	
- (5/		30. Name and address of person who Michael LaPenta,	MD 445 De	enfens	se Hig	hway A	Anna	apolis,Md	. 21401			
Sta Registra		31. Date filed (Month, Day, Year) MAR 1 4 2007	32. Registr	rar's Signatu	a de	7						

State Registrar DHMH 17 Rev 1/2001

1 - For State Registrar

Director

Funeral

Be Completed by

ဥ

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29b. Signature and title of certific

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show

Physician /Medical **Examiner**

For State	State	n warylan	•	artmen <i>rtificat</i>			anu iv	ntal Hyg			
Registrar . Decedent's Name (First, Middle	e (ast)			Tillicati	e or L	Jealii		2. Date of Dea	ith C	007	3 Time of Death
Doris Burnet		e							3, Day 20	07 Year	12:45P M
a. Facility Name (If not institution	, give street and nu	mber)		4b. City,	Town, or	Location of	of Death	1		unty of Deat	
8002 Oakwood L				Pomf						Char	
Social Security Number 220–32–6917	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. I	ast birthday, Yrs.	Months Months	Days	If Under	Min.	8. Date of Birtl (Month, Day 0ct. 10	(Vear)	38 Mar	hplace (State or Foreign untry)
Isual Residence of Decedent		- 00						000. 10	J, 1J.	70 Mai	yrana
0a. State 10b. County		10c. City	, Town or L	ocation							10d. Inside City Limits 1 ☐ Yes 2X No
laryland Charl	es				mfre	t		1.	10- 0''		
De. Street and Number 8002 Oakwood L	ano			10f. Zip	0675				rog. Grizer	of What Co US	unity?
1. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Deced	dent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No-	14.	Race - Ame	
1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	Armed Formed Formed 1 □ Yes If Yes, Given or D	2∕k∏ No ive		1 ☐ Yes		Specify:	i, Puerto	Rićan, etc.)	Sp	Black, White ecify:	∍, etc. White
15. Deceden (Specify only highe	t's Education st grade completed)		(Give	edent's Usua kind of wo	rk done d	during most	t of work	ing	16b. Kind	of Business/	Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		ро мот из eptio		<i>'</i>			US G	loverni	nent
7. Father's Name (First, Middle,	Last)	· · · · · · · · · · · · · · · · · · ·					r's Nam	e (First, Middle,			
Edward Eugene	Pickeral					Sal	1y /	Atchinso	n		
9a. Informant's Name/Relations				_				ral Route Numbe			Zip Code)
inda Gordon - Da. Method of Disposition	Daughter	20h B	9614 lace of Disp			t., L		lata, MD		ion - City or	Town State
1 Burial 2 □ Cremation		State	emetery, cre	matory or c	ther plac	1				•	
4 □ Donation 5 □ Other (S 21. Signature of Funeral Service			nity M	2. Name an						orf, M	ton Road
> John Hyd	IVIU	1391		luntt		_					
23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death		ter the mod	le of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
mmediate Cause (Final isease or condition	,	Ston	rach	Col	MC	erc	erth	- Meta	asta	258	Onset and Death
esulting in death)	Due to	(or as a consequ	uence of):		_						
Sequentially list conditions,	b. Due to	(or as a consecu) evot	ens	W.						
sequentially list conditions, any, leading to immediate ause. Enter Underlying cause (Disease or injury	6 500.0	(0) 40 4 00.009	201100 01):								
nat initiated events esulting in death) Last	C Due to	(or as a consequ	uence of):								
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 № No 9 □ Unknown	1 ☐Live	itcome pf pregna birth 2 □ Feta nant at time of d	I death 3	□Ectopic pi □ Other <i>(sp</i>					23d	. Date of del Month	ivery Day Year
rart II. Other significant condition	ons contributing to o	leath but not res	filting in the u	underlying c	ause give	en in Part I.	•	23e. Did to			the cause of death?
		-						24a. Was a		24b. Were au	itopsy findings available
								autop perfoi 1∐ Yes	med? 201No	death?	completion of cause of 2 ☐ No
							of Deat	th (Check only or			
	Hospital: 4 —	Inpatient 2 🗆	ER/Outpatie			4 LI Nu	rsing Ho	ome 5 Resid			cify)
examiner? 1 ☐ Yes 2 No				nt 5	28c Iniun	v at		28d. Describe h	ow injury o	ccurred	
	28a. Date (Mor	of Injury oth, Day Year) e of injury - At ho	28b. Time of Injury	М		k? Yes 2□	No				

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag

Washington Road, Swite 203A, Waltry Bleen & South 30. Name and oldress of person who completed cause of death (Item 23a) (Type, Prin 086 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 15 2007 Registrar

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_	State of Ma									egible.		
			1 - For State Registrar		., , (Death			Reg. No.	2007	0 5	3844
	Dhysisi		1. Decedent's Name (First, Middle, Last	t)						1	2. Date of Dea Month	ith Day	Year	3. Tim	e of Death
	Physicia /Medic		Harriet Ann Carr		ips						March	14	2007		:05 PM
	Examin	er	4a. Facility Name (If not institution, give 21 Roberts Way	street and number)					Location o	f Death			County of Deat	n	
_	Funeral		5. Social Security Number 6. Se		e (In yrs. la	ast birthday)	If Unde	rth E	If Under 2		8. Date of Birth	1	Cecil 9. Birtl	nplace (Sta	ite or Foreign
	Director		228-42-4557	□M 2ŽŠF	74	Yrs.	Months	Days	Hours	Min.	(Month, Da) Feb. 23			_{úntry)} rgini	a
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. fnsid	e City Limits
	Maryl	tor	Maryland Cecil		N	orth E	act							1 🗆 1	res 2 🔯 No
	th the	Director	10e. Street and Number			<u> </u>		Code				10g. Citiz	en of What Co	untry?	
	deeth with the Maryland me 23a or 28a-f show rmust be notified at	ral	21 Roberts Way					21901					ed Sta		
	item de	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Amed Forces? 1 ☐ Yes 2 X X		S. 13. \	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Orig n, Mexican	gin? (Spec i, Puerto R	cify Yes or No- lican, etc.)	1	4. Race - Ame Black, White		1,
9500-61212	hours after tural', or ite al Examine		3XXWidowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗆 Yeş	ZXNo	Specify:			3	Specify: Wh	ite	
ς O	72 ho 'natur dical	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>		16a. Dece (Give	dent's Usu kind of wo	al Occupa	ation during most	t of workin	g	16b. Kin	d of Business/	Industry	
7	within 72 ene. then "ne!	ldm	Efementary/Secondary (0-12)	Colfege (1-4or 5	i+)							Fi	re Dep	artme	nt
	filed Hygir other ant.	Be Co	17. Father's Name (First, Middle, Last)			Adill	II.LS L	aliv	re Ass 18. Mothe		(First, Middle,	Maiden S	Sumame)		
yland	D 9 7 0	To B	Garland Dudley (Carneal					Mary	Ann	a Titus	3			
Mar	2 should and Men le marke aumatic	V 9	19a. Informant's Name/Relationship (7			1	-					-	Town, State, 2		
	s 1 and 2 shou f Health and M frem 27 le mar other traumat		Judith L. Landers	- Jaught					_		East, M		and Z	1901 Town, State	
ב ב	Pages nent of int: If it		1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		ace of Disponentery, cres			·e)	Marci			burg,		
Baltimore,	교문문을		21. Signature of Funeral Service Licen	11-11-	0111			-	ss of Facility		uch Fur			VII MI	шта
מ	Depar Depar Impo any ir		23a. Part1. Enter the disease, or comp										st, Ma	ry1an	d 21901
	Cate be executed Physician and Physician and strenging the purial transit Physician and the physici	cal Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	a conseque	ienca of):	rend	-	n Cl3	·				Onset a	Between and Death
O. Box 687	of the death certificate by the ettending physicached for use as the lacked for use as t	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d23c. If yes, outcome 1	2 Fetal	death 3[⊒Ectopic p					23	3d. Date of del Month	ivery Day	Year
7.	thet the	P.	Part II. Other significant conditions co	ontributing to death b	ut not resu	ulting in the u	nderlyina	cause div	en in Part I.		23e. Did to	obacco us	se contribute to	the cause	of death?
Kecords,	The law requires thet ite has been signed b bage 2 should be deta										101	⁄es 2 ⊡	31√0 3 Pr	obably 4	Unknown
ပြု	aw requir is been si 2 should	Completed									24a. Was		24b. Were au	topsy findi	ngs available of cause of
ř		E O									perfor	rmed?	death?	2□ No	or cause or
Vital	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or.		Check only o				
5	Phys r this ral dir	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	rv	ER/Outpatier 28b. Time o		OA Injun	4 🗆 14 0		e 5 Resid		Other (Spe	city)	
0	death. ctor: After y the funer	atlor	1 ☑Naturaf 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Yeer)	Injury	м	Worl	k? Yes 2⊡!	No					
DIVISION	al or Attences after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At ho c. (Specify	me, farm, st	reet, facto	y, office		2	8f. Location (S City or Tox	Street and vn, State)	Number or Ru	ıral Route i	Vum <i>ber</i> ,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	f examinat	wledge, deat tion and/or in	h occurred vestigation	d at the tin	ne, date an pinion, dea	d place, a	nd due to the d d at the time,	cause(s) a date and	and manner as place, and due	stated. to the cau	se(s)
	To t To tl	Σ	29b. Signature and title of certifier	11212			29	c. Licens		11	,	-	signed (Mont		ir)
	,		7 7.10	way	land: ():	00-1 0	D-1 ii	DO	05	-10,	08	2	- 15.0	1	
	U		30. Name and address of person who of	CALL / / / / / / / / /	lich t	23a) (1ype.		J4	EIK	ton	MD	213	192		
N.	Sta		31. Date file (Month, Day, Year)	//32. Registr	ar's Signa		M .								
	Registi	ar	7007	MICHELLE	J.	4004	W								

Amend it	om.	1 = For State Registrar #26 per D						and M	lental Hygio	ene g. No. 2 ()	07	09845
Amena 10	CIII	Decedent's Name (First, Middle, I	Last)	-22-0//u	15				2. Date of Death			3. Time of Death
Physici		Lewis	W Por	due, Sr					Month 3	Day 8	Year 2007	3:30 P M
/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	or Location o	f Death		4c. Count		3.30
LAGIIIII	307	6943 Zion Churc	h Road			Salisb	11237			Wico	miaa	
Funeral			. Sex 7. /	Age (In yrs. last t	birthday)	If Under 1 Year	If Under 2		8. Date of Birth		9. Birtho	place (State or Foreign
Director		220-01-4871	1 MM 2□ F	87	Yrs.	Months Days	Hours	Min.	(Month, Day, 19-19-19	19	Ma	rvland
p.		Usual Residence of Decedent										
with the Maryland s or 28a-f ehow be notified at	_	10a. State 10b. County		10c. City, To	wn or Loca	ation					1	Od. Inside City Limits
Ba-f	cto	MD Wicom	ico	Sali	isbur	У						1 Yes 2X No
or 20	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?
within 72 hours after death with the Maryland see.	B	6943 Zion Church	n Road				1804			USA		
urs after death v al', or Items 23s	Funeral	11. Marital Status	12. Was Deceder Armed Force	s? 1037_	13. W	as Decedent of H	lispanic Orig	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	
of 2 should be filed within 72 hours after than dental Hygiene. 27 is marked other than "natural", or list traumatic event, it is Mudical Examin		1 Never Married 2 Married	1 X Yes 2	1957 1957		☐ Yes 2X No				Speci		ite
72 hours "natural",	d by	3 N Widowed 4 □ Divorced	Year or Dates	3:							- 1111	
"natur	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16	(Giva ki	nt's Usual Occup nd of work done	during most	of works	ng 16	6b. Kind of E	Business/In	dustry
yene.	ф	Elementary/Secondary (0-12)	College (1-4a	r 5+)		NOT use retire	a)				C 26	
led lygid her ht,	ပိ	17. Father's Name (First, Middle, La	asl		Man	ager	40 14-15-		(First, Middle, Ma			ryland
be filed ntal Hyg ed other event,	Be		•								me)	
d Meu	T ₀	Lawrence H. Pe							est - De			
n and		19a. Informant's Name/Relationship	, , , ,		_				l Route Number, (•		
ages 1 and 2 should be fi nit of Health and Mental H t: If item 27 Is marked ot y or other traumatic ever	H	Juanita Perdue F	lomer - da	ughter 4	14 Mi	idland T	errace	e. S	alisbury	. Mary	land	21804
ges toth Fite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from Stat	00000	tery, crema	itory or other pla	ce)	L	20	Oc. Location	- City or Ic	own, State
Pa tmen tant: jury		4 ☐ Donation 5 ☐ Other (Spec		Jerusa		Cemetery	7	3-12	-2007 Fa	rsonst	our.	Maryland
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lic	ensee A/	/	22. !	Name and Addre	ss of Facility	Bou:	nds Fune	ral Ho	me	
₫ Q ⊑ # O		1/1/10/10/10	and to	re	705	E. Mai	n Stre	eet,	Salisbu	ry, Ma		d 21804
8.* *		23a. Part1. Enter the disease, or co shock, or heart failure. List of	polications that caus y one cause on each	ed the death. Do	o not enter	the mode of dyir	ng, such as o	cardiac o	r respiratory arres	st,		Approximate Interval Between
Physician		Immediate Cause (Finat disease or condition		ASCI	21							Onset and Death
/Medical		resulting in death)	Due to (or a	as a consequenc	e of):							
Examiner	4	A TO CHARLES THE TOTAL OF										
3	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	is a consequenc	e of):							
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be executicien and burial-tran	resulting in death) Last Due to (or as a consequence of):											
tte be ex tysicien ne burial	Cal		d.						****			
as been signed by the ettending physics should be detached for use as the last	Med	fF FEMALE:										
r use	an/	23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Fetal dea	th 3∏F	ctopic pregnancy	v				ate of delive	
the ett	200	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4 Pregnant	at time of death		Other (specify)	,			M	onth	Day Year
ed by the detached	Physician/Medi	9 🗌 Unknown	9□ Unknown									
gned be det	by P	Part II. Other significant conditions			in the und	erlying cause giv	ven in Part I.		23e. Did toba	cco use con	tribute to th	e cause of death?
been sig	pa	Diabetes	s melli	tus					1 ☐ Yes	2 N o	3 🗌 Prob	ably 4 Unknown
as bee 2 sho	olet	Hynov te	nsion						24a. Was an	24b.	Were auto	psy findings available
<u> </u>	Completed								autopsy performe	ed?/	prior to con death?	mpletion of cause of
certificate ha rector, page	0	25. Was case referred to medical					ne Di	of De-i	1 Yes 20	No	1 🗆 Yes	2LJ No
is certific director,	0	examiner?	Hospital:	ADER/	Duta-+:+	3D DOA Oth			Check only one			
r this aral di	5: To	27. Manner of Death	28a. Date of In	1011 2 ER/C	Outpatient Time of	3LI DOA	4 🗀 Nur		ne 5 Z Residen 28d. Describe how			y)
r death. ctor: After this certification the funeral director.	Certification;	1 Natural 5 Pending 2 Accident investigat	(Month, E	Day Year)	Infury	28c. Injur Wor M 1	rk? Yes 2 □ N					
deat ctor: / the	ica	3 ☐ Suicide 6 ☐ Could not	be on Dian of	njury - At home,	farm stree				28f. Location (Stre	at and Num	har or Pura	J. Pauta Number
Dire in b	erti	4 Homicide determine	building,	etc. (Specify)	141111, 31100	n, lactory, office			City or Town,	State)	DOF OF FILITA	i Noule Ivamber,
ours eral		29a Certifier 1 Certifying I	Physician: To the her	et of my knowled	go doath a	annered at the tir	mo data and	d place 4	and due to the cou	(-)		
within 24 hours after death. To the Funeral Director: A Completely filled in by the fu	edical	(Check only 2 Medical Ex	Physician: To the bes animer: On the basis and manner:	of examination a	and/or inve	stigation, in my o	pinion, deat	h occurre	and due to the cau ed at the time, date	se(s) and m e and place,	anner as st and due to	the cause(s)
thin the mple	Mec	29b. Signature and title of certifier	and manner	otatou.		29c. Licens	a number		200	d. Date signe	nd (Month	Day Yearl
COTE				100.10		be	ر در د بیسه	7		2. Date signe	12	1,7
200)	mo		DS	5412	+		3	10	10 /
12v		30. Na and address of person wh	7	death (Item a	i) (Type, Pr	int) < 1	9 1	1	14.5	Circle Control	19 100	ne C
		21 Date filed (Month Day Vo.	S MO	100 10	WEV	JT.	201	150			4.1%	09.
Sta Registr		31. Date filed (Month, Day, Year)	No.	trar's Signature		,			0			
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		The state of the s		For State Registrar	State of M	Marylan		artmer rtificat			and M		giene Reg. Ne	211117	09846		
		Physici	an	1. Decedent's Name (First, Middle, L.								2. Date of De Month	Da	Year Year	3. Time of Death 10:25 A M		
		/Medio	cal	Earl Timothy 4a. Facility Name (If not institution, gi	Price	er)		4b. City.	Town, or	Location of	1	March 2		County of Deal			
		Examir	ier	Harford Memoria						e Gra				Harford			
		Funeral Director					last birthday) Yrs.	If Unde	r 1 Year Days	If Under Hours		8. Date of Bir (Month, Da 9/24/1	th 19, Year) 942	9. Bin Co Mar	thplace (State or Foreign cyland		
		pu k		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ncation							10d. Inside City Limits		
		Marylis f sho	Į.		ford		erdeer								1%XXYes 2 ☐ No		
		death with the Maryland rms 23e or 28a-f show r raist be notified at	i Direc	10e. Street and Number 66 Dixon Avenue					Code 21001				-	izen of What Co	puntry?		
a B	36	within 72 hours after deat ene. then "neturel", or Items 2 for Medical Examiner ma	by Funeral Director	11. Marital Status 1 ★ Never Married 2 → Married 3 → Widowed 4 → Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? XNo	1	Was Dece If Yes, spe 1 Yes		spanic Ori n, Mexican Specify:		city Yes or No Rican, etc.))-	14. Race - Ame Black, Whit Specify: W			
13	215-0036	72 hou natura	eted	15. Decedent's I			16a. Dece	dent's Usu	al Occupa	ation during mos	t of workir	70	16b. K	ind of Business	/Industry		
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	CA	iled tygi her nt.		10 17. Father's Name (First, Middle, Las	<u>(1)</u>		Pack	rer		18. Mothe	er's Name	(First, Middle			Storage		
1	/lan	Q 22 Q	To Be	Clifford H. Pri	ce					Rut	h L.	Homer					
3/22/0	Maryland		ď	19a. Informant's Name/Relationship			19b. Maili 66 Di	•						or Town, State, 2 and 210			
8		1 an Heal Fm 2		Dorothy Carty (sister)	20b. F	Place of Dispo	osition (Na	me of	-		een, Ma		ocation - City or			
3	DE L	Pages nent of I int: If Ite		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		110	emetery, cre A. Fe			1	3/23/	' 07	West	Cheste	er, PA		
V. 1	Baltimore	permit. Page Department Important: If eny injury o		21. Signature of Funeral Service Lice	ensee	gra						al Home 21001-					
	·	Physician		23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition		sed the deal	A	ter the mo	de of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death		
		/Medical Examiner		resulting in death)	Due to (ok	las a consecutive of the consecu	juence of):	om	4	J					1 WK		
S	J	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):												
Of	, ° 2	ite be executed sysicien and ne burial-transit		that initiated events resulting in death) Last	c. Due to (or	as a consec	juence of):										
	687	± ≥ 6	edical		d												
_	O. Box (The law requires that the death certifical tite has been signed by the attending phyoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2∏Feta tat time of d	death 3	⊒Ectopic p ⊒ Other (s						23d. Date of de Month	livery Day Year		
\	ds, P.	uires that the signed by	þ	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	underlying	cause give	en in Part I			tobacco Yes 2		o the cause of death?		
-	ecor	e law requir has been si je 2 should	Completed									24a. Was		24b. Were a	utopsy findings available completion of cause of		
17	Ä	The Tate his page	Com									perfo 1 ☐ Yes	2 No	death?	s 2□ No		
7	Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Of Othe	n.c.		Check only					
	of	Phys this ral dir	٠ <u>.</u>	1 Yes 2 No 27. Manner of Death	1 LXInp		ER/Outpatie		04	4 [] 14(ne 5 Resi 28d. Describe		6 ☐Other (Spe	ecify)		
	Division of	ath. rath. r: After	ation	1 Autural 5 ☐ Pending 2 ☐ Accident investigati		Day Year)	Injury	М	28c. Injun Work 1 []	k? Yes 2 □		ou. Bosonibo		ny ocoumeu			
	Divis	the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica npletely filled in by the funeral director.	Certification:	3 Suicide 6 Could not 4 Homicide determine	a 28e. Place of	98 Open Class of Injury. At home form street factors office.						28f. Location (City or To			ural Route Number,		
		To the Hospi within 24 hour To the Funer completely fill	edical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ex	miner: On the basi	sician: To the best of my knowledge, death occurred at the time, date and place, and due ner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.						and due to the ed at the time,	cause(s date an) and manner a d place, and du	s stated. e to the cause(s)		
		To the within 2 To the complet	Me	29b. Signature and title of certifier	^	110		29	c. License	number			29d. Da	te signed (Mon.	ed (Month, Day, Year)		
		^	9) lwh	im	(Vy)			D.	5 46	04		3	12310			
		3		30. Name and address of person wh	o completed cause of Municipal Completed Cause	or death (Ite	m 23a) (Type	Print)	tives	st .1	far	nse	Gra	au m	21078		
	100	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Reg	istrar's Sign	ature	PL.			7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SR /Medical Town, or Location of Death County of Death Facility Name (If not institution, give street and number) Examiner 1 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 M 2 □ F Director 10-27-30 MARYLAND 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Stockton Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ROAd 21864 UNITED by Funeral SNOW HILL TEO STATES

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 952
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) TYSON Elementary/Secondary (0-12) College (1-4or 5+) 12 DRIVER FARMS 12 should be filed wand Mental Hygien is marked other the injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HNdrew SERTHA WATERS ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 2 and 1 and 2 an Stockton, md James (SON) 7.0. BOX 147 20b. Place of Disposition (Name of cemetery, crematory or other place) . Method of Disposition 1 Burial 2 ☐ Cremation Date 20c. Location - City or Town, State 3 ☐Removal from State Beneficial Cem. 3-17-07 Stockton, m 22. Name and Address of Facility 819 Fourth Street 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bennie Smith Pocomoke, Md Home FUNETAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) elei Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) □Yes 2□No Division or Vital Records, P.O. the detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No funeral director, page 2 autopsy e Hospital or Attending Physician: 24 hours after death. e Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 Inpatient 1 Tes P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: l 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058410

BA3+1

State Registrar GHUAM WA 31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 1 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARIS

Box # 1733

07-01890

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

se Portillo		1- For State Registrar	Sta	ate of Maryland		artment of rtificate of		and Ment	ai riygi		1. No. 20	27-	-09848
Physicia ledical Exami	an/	Decedent's Name		e,Last)					2. D	oate of Death Nonth arch 10, 2	Day Year		3. Time of Death 1027 hrs
reulcai Exaiiii		Jose Porti 4a. Facility Name (if		n, give street and number)	4	b. City, Towr	n, or Location of		aich 10, 2	4c. County o	f Death	
		Suburban H	ospital		_		Bethesd		e de la		Montgom		
Funeral Director		5. Social Security N 578–94–3806	umber		ge (In yrs.)	last birthday) Yrs.	If Under 1 Months	Year If Under Days Hours	1	ept. 8,	•	9. Birth Cour El. S	place (State or Foreign alvador
any		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Location	on ·					1	0d. Inside City Limits
	٦	MD	Montga	nery	Silv	ver Spring	5						1 Yes 2 X No
Maryland 28a-f show datouce.	Director	10e. Street and Nur	nber		<u> </u>		10f. Zip Co			10	g. Citizen of Wh	at Counti	y?
death with the Maryland or items 23a or 28a-f sho must be notified at once.		12104 Veir	s Mill	Road 12. Was Deceder	t Ever in II	18 142 Wa	20906	f Hispanic Origi	n? (Specify	/ Ves or No.	USA 14 Race	- America	an Indian, Black,
eath wi	Funeral	 Marital Status Never Mame 	ed 2 XM	arried Armed Forces	?			uban, Mexican,			White		
	by Ft	3 Widowed	4 Div	orced If Yes, Give Year	2 X No			No specify:				Whit	
hours.		15. Decedent's Ed Elementary/Seco		cify only highest grade co		16a. Decedent	t's Usual Occ ost of working	cupation (Give k g life. DO NOT u	ind of work use retired)	done	16b. Kind of Bus	siness/Ind	dustry
36 Ihin 72 te. than '	Completed	12	ildaly (0+12)	College (1-4 of	3.)	Labor Fo	oreman				Concrete	Co.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle,	Last)							aiden Surname)		
2121 ould be fil I Mental I marked	ജി	Jose Ruber 19a. Informant's Na	to -Para	da		19b. Mailing	Address (1	isca Po		ber, City or Town	n, State, i	Zip Code)
MD 2 Id 2 shou lith and 1 m 27 is 1	-	Rosa E. Po				12104	Veirs N	fill Road	Silver	Spring	, MD 2090)6	
re, re, s 1 and f Healt		20a. Method of Disp		3 Removal from S		Place of Disposi crematory or oth		of cemetery,	Da	ite	20c. Location -	City or T	own, State
Baltimore, permit. Pages I at Department of He Important: If ite		4 Donation 5	Other Sp	pecify:		te of Hear	ven	description of Equipment	3/14/20	007	Silver S	Spring	g, MD
Ball permit Depart Impor		21. Signature of Fu		i, per DVR		924	ame and Add	bia Blvd.	Milip Silver	ש. אנוא Spring	g, MD 2091	.0	rvice,
Physician		23a, Part I. Enter th failure. List on	e disease, or	complications that cause	d the death								Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	_{a.} Pneumonia									Death
		or condition resulting		Due to (or as a con	sequence (of):							
	ner	Sequentially list con if any, leading to im- cause. Enter Under	mediate	Due to (or as a con-	sequence	of):	-						
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60, ate be ex hysician e burial	Medical	UNPENDED		X AMENDED Ite	m//17,p	erINF.,G8	78,4/7/	08,WS		_	23d. Date of	delivery	
Records, P.O. Box 68760, The law requires that the death certificate be executed treate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	an/N	23b. Was decedent past 12 months	pregnant in ti ?	ne 1 Live birth		2 Fe	tal death		pregnancy		Month	Da	y Year
Box (e death ce the attence of for use	Physician/N	1 Yes 2 1	No 9 🔲 Uni	4 Pregnant a	at time or a	eath 5 Oti	her (Specify)						
O. E at the d d by thy		Part II. Other signi	ficant condit	ions contributing to dea	ith but not	resulting in the u	inderlying ca	use given in Par	rt I.		parents of		ne cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach.	Completed by	Chronic Ale	cohol Abu	se					-	1 Yes			bly 4 Unknown
of Vital Records, ng Physician: The law requir Nfer this certificate has been s meral director, page 2 should	nplet									autops perform	y p med? d		mpletion of cause of
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ion of Vital frending Physician: teath tor: After this certifi	o Be	25. Was case refer examiner?	2 No	The section is	ient 2	ER/Outpatient		Other			Residence 6	Other:	
on of \ cending Plr, sath or: After ti		27. Manner of Deat		28a. Date of In (Month, Day	jury ,Yeer)	28b. Time of I	njury 28c	. Injury at Work		. Describe h	ow injury occurre	ed	
Division tal or Attendii rs after death al Director: A	Certification:	1 V Natural 2 Accident	5 Pen	stigation	leuwy At h	nome, farm, stree	at factory of		No 28f	Location (S	treet and Number	er or Rur	al Route Number, City
Divisi pital or Att curs after d reral Direct filled in by	ertifi	3 Suicide 4 Homicide		Id not be mined (Specify)	ilijury - Aci	ione, am, succ	st, lactory, or	ince senting, ou		or Town, St			,
Divis To the Hospital or Ave within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier	Certifying P	hysician: To the best of	my knowle	dge, death occur	red at the tim	ne, date and pla	ce, and due	to the cause	e(s) and manner	as state	i.
To the Hos within 24 h To the Fun completely	Medical			miner: On the basis of ex and manner states	amination	and/or investigat		inion, death occ	curred at the	e time, date a	and place, and d		
	Σ	29b. Signature and	A A	1 /1				C.M.E.			March 11, 2		, 20, 000
		30. Name and addr	ess of persor	who completed cause of	death (Iter								
		Jack Titus I	ND. Dej	outy Chief Medical	Examine	er 111 Per	n Street,	Baltimore, N	MD 2120	1			
S Regis	tate		th, Day Year)	2007 32. Registr	ar's Signa	ture Anach	00						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Sabrina Shea Parker

past 12 months? 1	
As Facility Namer (if not institution, give street and number) Carroll Hospital Center Carroll Hospital Center Social Security Number 18 - Social Security Number 18 - Social Security Number 19 - Social Residence of Decement 10 - Country Mary Land 10 - Country M	
S. Social Security Number 218-77-77000 Security Number 218-77000 Security Number 218-77-77000 Security Number 218-77-77000 Security Number 218-77-77000 Security Number 218-77000 Security Numbe	
218-77-7700 1 M 2 XF Month 3 Days Months D	
Usual Residence of Decedent 10a State 10b County Mount Airy Maryland Carroll Mount Airy 10c Cry, Town or Location Mount Airy 10c Street and Number 5810 Leslie Lane 11 Markel Status 11 Never Married 2 Married 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin' (Specify Yes or No. 14 New Parties) 11 Never Married 2 Married 11 Never Married 2 Married 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin' (Specify Yes or No. 14 New Parties) 14 New Parties 15 Decedent's Education (Specify only highest grade completed) 16 Decedent's Education (Specify only highest grade completed) 17 February Secondary (0-12) 18 Indicarrant's Name(First, Middle, Last) Derrick Lee Sylvester Parker 19 Derrick Lee Sylvester Parker 19 Derrick Lee Sylvester Parker 19 Derrick Lee Sylvester Parker 19 Derrick Lee Sylvester Parker 19 Derrick Lee Sylvester Parker 19 Derrick Lee Sylvester Parker 20 Member of Disposition 19 Derrick Lee Sylvester Parker 20 Member of Disposition (Specify or Disposition (Specify Code) 20 Member of Disp	
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Derrick Lee Sylvester Parker Angela Faye Seal	
Derrick Lee Sylvester Parker Angela Faye Seal	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number. City or Town, State, Zip Code)	
20a. Method of Disposition Date	
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth—Willliams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 2087 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Or Deat 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Or Deat 27 Name and Address of Facility Molesworth—Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 2087 Approximate Between Or Due to (or as a consequence of): 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Or Due to (or as a consequence of): 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Or Due to (or as a consequence of): 25a. VINPENDED 25a. VINPENDED 25a. Marender 25a. Was decadent pregnant in the Due to (or as a consequence of): 25a. Marender 25a. Was decadent pregnant in the Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25b. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25d. Due to (or as a consequence of): 25d. Due t	
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29 A. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29 A. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title offcertifier 29c. License number 29d. Date signed (Month, Day, Year)	
O.C.M.E. March 16, 2007	
30. Name and address of person who completed cause of death (Item 23a)	
Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 Hilda V. Quick arch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Doctors Hospital Lanham 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Feb. 20,1924 North Carolina If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F Days Hours Min 83 579-26-3608 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show at X Yes 2 No be notified Director Maryland | Prince Georges Lanham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 10011 Ellard Drive 20706 United States 2 should be filed within 72 hours after death w and Mental Hygiene. Is marked other than "natural", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Widowed 4 ☐ Divorced Completed by 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government 12 Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie Blanchard Joseph G. Simpson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10011 Ellard Drive, Lanham, MD 20706 Roy D. Quick - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lincoln Memorial Cem: 3/17/07 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses 7400 Georgia Ave. N.W., Washington, DC 20012 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Infar chion Immediate Cause (Final Myocardial hr. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** la betes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oue to (or as a consequence of) Examine be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.0. Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by completely

Medical

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 1 4 2007



and manner stated.

Twally I,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0042684

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2:30 PM **Physician** 2007 Marci Mae Frances Russell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Prince George's

9. Birthplace (State or Foreign Country) Lanham If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F Yrs. Director 59 1947 258-76-9368 Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo Capitol Heights Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 United States 319 Carmody Hills Dr. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "nature" any injury or other transmitter. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 反 No Specify: Black. Specify: ģ 3 ₩ Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Sales Associate</u> Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Graham Lettie Mae Babbit 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Carmody Hills Dr., Capitol Heights, MD 20743 LaTrice Russell/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/19/2007 Hagan Cemetery Hagan, GA 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Stewart Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

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MYOCAROLAL IN FARCTION Drewer Wash., DC 20019 **Physician** INFARCTION. /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 WUnknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à SEIZURE DISORDER 2 No 3 Probably 4 Ukknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician this

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as the for use þ pe page 2 should director. filled in by the funeral After Hospital or Attending after death Director: 24 hours a Funeral I

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within 2 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESHKUMAN STIL SARVIS AVENUE, RIVERDALE, MID HTATTUM 31. Date filed (Month, Day, Year) MAR 1 5 2007 32. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

29a, Certifier (Check only one)

29b. Signature and title of certifler

MM

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0058290

29d. Date signed (Month, Day, Year)

	For State Registrar	State of N		epartment o		nd Mental H	ygiene Reg. No. 2	007	09852				
Physician	1. Decedent's Name (First, Mid	dle, Last) RHODES ROBER	RTS	-		2. Date of E Month March	Day	200 7	3. Time of Death				
/Medical Examiner	4a. Facility Name (If not institut			4b. City, Tow	n, or Location of		-	unty of Death	4302				
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Funeral Director	5. Social Security Number 218–18–0490		Age (In yrs. last birt	hday) If Under 1 Ye Months Da		Min. (Month, L	Birth (Day, Year) 2, 1920	Cour	place (State or Foreign htry) YLAND				
pu ,	Usual Residence of Decedent		10c. City, Town	or Location				1	I Od, Inside City Limits				
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Hygiel Her th	17. Father's Name (First, Midd.	4 (a ast)		ARTIST	18. Mothe	r's Name <i>(First, Midd</i>		F EMPL	OYED				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notifiled at once. To Be Completed by Funeral Director	THE MED TO AN					IE ANDERS							
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Division or Vital Records, P.O. Box 68760,

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: I Director: / within 24 hours at To the Funeral C

Registrar

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David J. Tardio MD 110 Hospital
31. Date filed (Month, Day, Year) 32. Registy's Signatu

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ा Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Lane Suite 310 Prince Frederick MD 20678

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month **Physician** March 15, Garie Alexandria RICHARDSON 6:50 a. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington 1064 Noland Drive If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, You Aug. 19, 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days 1 □ M 2 🕅 F 60 1946 233-76-5190 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Innert of Health and Mental Hyglene. and if item 27 is marked other than "natural", or items 23a or 28a-f show ant; if item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XTYes 2 ☐ No Director Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 USA 1064 Noland Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: black þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) secretary government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Hairston Oscar King ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1064H Noland Dr., Hagerstown, Maryland 21740 Lisa Wilson - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Hagerstown, Maryland 3/16/07 Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MINNICH FUNERAL HOME E. Wilson Blvd., Hagerstown, Maryland 21740 415 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mount disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2[1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Tes 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death uneral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. within 24

CZ-3

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) MAR 19

Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD

M

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** M Frank William Ruppert, Jr /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner erstown Vashir Washington County Hospital 5. Social Security Number | 6. Sex | 7. April 1981 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 🖫 M 2 🗆 F 83 215-12-0490 Director October 22,1923 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2√ No Director Washington Hancock 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 9 Sable Run Road 21750 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates 1943-1945 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygien tem 27 is marked other th 12 Time Study Engineer Engine Parts Manufacture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ <u>Elizabeth Bremker</u> Frank William Ruppert, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank W. Ruppert, III/Son Sable Run Road Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Smithsburg Crematory 03/22/07 Smithsburg, MD 21 Signature of Funeral Service Licenses 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and burial-trar the attending physician Physician/Medical the IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 mont Month Day Year onths? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes director, page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an certificate has autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Coul — to d trmined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, or Attending hours after death filled in by Hospital within 24 hours a completely

> State Registrar

2

29a. Certifier

29b. Signatu

Medical

and manner stated

ertifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

ampus Rol. Ste 127 Hagerstown, MIS 2174

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Stata Registrar	State o	f Marylar		artmen rtificate				lental Hy	gienę Reg. No.		7	09	857
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	/Medi	cal	Thelma A. Ro				4h Cihi	T	.l. aaatiaa	-4 Danah	March		2007 County of (Donath.	12:20	O A M
	Examir	ier	4a. Fecility Name (If not institution Prince Georges	-			Cheve		Location of	or Death			ince		* ******	
	Funeral		5. Social Security Number	6 Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birt	th		Birthp	lace (State	e or Foreign
п	Director		265-20-4861	1□ M 2☐F	81	Yrs.	Months	Days	Hours	Min.	(Month, Da Aug. 2	6,19	25 F	1 or	ida	
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	28a-	rect	10e. Street and Number		was	SILT IIE C	10f. Zip	Code				10g. Citi	zen of Wha	t Coun	itry?	
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	ms .	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U	l.S. 13.	Was Deced	lent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - A Black, V			
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2	be file tal Hy d oth	Be	17. Father's Name (First, Middle,	Last)							e (First, Middle,	Maiden	Sumame)			
字	Men Men Marke Marke	2	Ed Hunter					12			eckum					
Maryland	d 2 st th and 7 is n treun		19a. Informant's Name/Relations Charles M. Hall				-				N.W., #			,		nc2000
ē,	Heall Heall tem 2		20a. Method of Disposition		20b. F	Place of Dispe	osition (Nan	ne of	1		Date		cation - Cit			502000
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturet", or items 23a or 28a-f ehow any injury or other treumatic event, Ita Medical Examiner must be notified at once.		21. Signature of Funeral Service			2	2. Name an	Cemetery 3/17/07 Washington, DC me and Address of Facility McGuire Funeral Service, Georgia Ave. N.W., Washington, DC 20						e. Ir	ıc.	
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P.O. Box	that the death certific ed by the attending p detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown		oirth 2 ☐ Feta nant at time of c	al death 3[□Ectopic pr □ Other (sp					2	23d. Date of Month		Day	Year
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Division of Vital Records,	ilcian: The law requires that ilcian: The law requires that that certificate has been signed the rector, page 2 should be determent.	e Completed	25. Was case referred to medical						00 0	24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Munkno 24b. Were autopsy findings availa prior to completion of cause death? 1 Yes 2 No 1 Yes 2 No				s available cause of		
>	yslcis is cert direct	0 0	examiner? 1 ☐ Yes 2 1 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DO	A Othe	200		n <i>Check only o</i> me 5 ☐ Resid		6 □Other (Specifi	<i>(</i>)	
פר	Attending Physician: r death. ector: After this certifics by the funeral director. I	T :u	27. Manner of Death	28a. Date		28b. Time o		8c. Injun			28d. Describe h			<u>ароон</u> у	/	
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1	Sta	te	31. Date filed (Month, Day, Year)	2007 32	egistrar's Signa	ature	Colt.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 9:20P March 20 Frenzie Caroline Stottlemyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 208 S. Second St. Woodsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Mar. 7, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 TF 203-10-8920 Yrs. 91 Pennsylvania **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov notified at 1 XYes 2 ☐ No Directo Maryland Woodsboro Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 21798 U.S.A. 208 S. Second St. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than the Mr Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home Ith and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dehoff Thomas Anna King ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. Doris L. Willard/ daughter 1095 Water Dr. Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 3/26/2007 Keysville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licensee 404 S. Main St., Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNG CANCER (PROBABLE NON-SMALL CELL MTUS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Box 68760, 8 Due to (or as a consequence of): physician a the burial-1 Physician/Medical 38 IF FFMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DOMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e 2 autopsy performed: 2□No 2 1Vo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No ပို 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. within 24 hours aft

To the Funeral D

completely filled in

Registrar

Medical

RICHARD 31. Date filed (Month, Day, Year) State

(Check only one)

29b. Signature and title of certifier

60064 PO BUX 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1)32171

WALKERSVILLE

29d. Date signed (Month. Dav. Year)

22/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrer	State of M	Maryland /		artment o			nd Me	ental Hy	giene		The second	098	59
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last Johnnie Shoulders As. Facility Name (If not institution, give	, Sr.	or)		4b. City, Tow	n, or Loc	ation of		2. Date of D Month	h Day		ear 01 Death	3. Time of	Death Q M
	Funeral Director		720-12-2353	01	M&K Age (In yrs. last 86	birthday) Yrs.	If Under 1 Y	ear If	Under 24 lours	4 Hrs. Min.	Month, D 6/6/1	rth a <i>y, Year)</i> 920	9	Birthpl Count NC	ace (State o	or Foreign
	ith the Maryland or 28e-f show	Olrector	Usual Residence of Decedent 10a. State 10b. County MD P.G. 10e. Street and Number		10c. City, To			de				10g. Citi	zen of Wha			ity Limits 2 No
5-0036	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland entiment of Health and Mental Hygiene. crtent: If item 27 is marked other then "naturel", or Items 23e or 28e-1 show njury or other traumatic event, I'm Madical Experiment must be notified at high or other traumatic.	eted by Funeral Director	5999 Emerson St. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra		s? ⊠No s:	6a. Deced	Was Decedent if Yes, specify (of Hispar Cuban, M No Sp	pecify:				14. Race -	White, 6	ack	
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	and 2 should be I ealth and Mental I n 27 is marked o	Tol	Tom Shoulders 19a. Informant's Name/Relationship (1) David A. Shoulder				ng Address <i>(Sti</i>	reet and I		or Rural				ıte, Zip		-avail
Baltimore,	pern it. Pages 1 a Deportment of Heis Importent: If item any njury or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen)	20b. Place ceme	of Dispo etery, cren Linc	sition (Name of natory or other o1n Cen	f place)		Da	2007	20c. Lo	cation - Cit	, MI)	
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8760,	And the prize transit the prize transit the prize transit the prize transit tr	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leadin, to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Sta	s a consequence IV a consequence a consequence a consequence	ce of):	Cance	1							Onset and I	lays
O. Box 68	death certifi e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal dea at time of death		Ectopic pregna					2	3d. Date o Month		•	Year
ords, P.	The law requires that the de ite has been signed by the a page 2 should be detached f	by	Part II. Dether significant conditions of	entributing to death	but not resulting	g in the ur	nderlying cause	given in	Part I.		1				e cause of d	
Vital Records,		Be Completed	25. Was case referred to medical					26.	Place o	f Death	1 ☐ Yes	psy ormed? 2 X No	24b. Wer prior deat 1 [to com	sy findings a pletion of ca 2 No	available ause of
Division of V	To the Hospitel or Attending Physiciem: within 24 hours after death. To the Funerel Director: After this certification pletely filled in by the funeral director, completely filled in by the funeral director.	Certification; To E	P 1 Yes 2 XNo Hospital: 1 ☑ Inpatient 2 □ ER/Outpatient 3 □ DOA Other.								4 Nursing Home 5 Hesidence 6 Other (Specify)					
N N	dospitel or Att t hours after de unerel Direct ely filled in by t	edical Certific	3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medicel Exem	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of City or Town, State) 28f. Location (Street and Number or Rural Route Number of Rural Route Number or Rural Route Number Number or Rural Route Number or Rural Route Number or Rural Rou												
	To the Hos within 24 h To the Fun completely	Medi	29b. Signature and title of certifier	and manner	stated.		29c. Lic	ense nun	nber		at the time,	29d. Date	signed (M	Month, D	ley, Year)	,
	Sta Registr		30. Name and address of person who of the filed (Month, Day, Year) WAR 15 2007	n 5	death (Item 23a hui -	4,561	print) of		alnm							

State of Maryland / Department of Health and Mental Hygiene

	7 - State Registrar		Ce	rtificate of	Death		Reg. No.			
186	Decedent's Name (First, Mid	dle, Last)				2. Date of De	eath	3. Time of Death		
Physician	LUCY	WILLIAM SHE	RVINGTON			MARCH	6 2007 Year	5:32 PM		
/Medical Examiner	4a. Facility Name (If not instituti		21,0201	4b. City, Town, o	or Location of Dea		4c. County of Death			
Examinier	16010 Excal	·1	1/00			•••				
	5. Social Security Number	# 0	1403 In yrs. last birthday)	Bowie If Under 1 Year	If Under 24 Hr	S. 8. Date of Bi	Prince Ge	eorge's iplace (State or Foreigi		
neral ector		1□M 2kg F 80	Yrs.	Months Days	Hours Min	. (Month, D	ay, Year) Col	intry)		
ctor	Usual Residence of Decedent	00				10-5-1	1926 NEW ,	JERSEY		
event, the medical examiner interior integral Be Completed by Funeral Director	10a. State 10b. Coun	ty 10	Oc. City, Town or Lo	ocation				10d. Inside City Limits		
ō	MD D							1 ☑ Yes 2 ☐ No		
act o	MD Prine	ce George's	Bowie							
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	intry?		
<u>a</u>	16010 Excalib	ır Rd # C403		20716			USA			
Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specify Yes or Ne	o- 14. Race - Amer Black, White	ican Indian,		
臣	1 Never Married 2 Ma		i	1 ☐ Yes 2 ☒ No	Specify:	110 1 110411, 010.)				
þ	3 ☑ Widowed 4 ☐ Divorce	Year or Dates:		TES ZENO	эрөспу.		Specify: Bla	CK		
Completed	15. Decede	ent's Education	16a. Dece	dent's Usual Occup	pation	- 4	16b. Kind of Business/Ir	ndustry		
를	Elementary/Secondary (0-12)	est grade completed) College (1-4or 5+)	life.	kind of work done DO NOT use retire	d) auring most of wo	orking				
E	Elementary/occordary (o 12)	5+	Regi	ster Nurs	se		Private	Private		
C	17. Father's Name (First, Middle	a, Last)	11.082	DOUL HOLL		ame (First, Middle	, Maiden Surname)			
Be	Charles Doug	las			Helen A		,,			
2	0		481	• • • • • • • • • • • • • • • • • •						
1	19a. Informant's Name/Relation						per, City or Town, State, Zi			
	Kirk A. Willi				ır Rd. #0		ie, Maryland	20716		
	20a. Method of Disposition	n 3 □Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ce)	Date	20c. Location - City or T	own, State		
	4 Donation 5 Other		Evergreen		2/1	19/2007	Brooklyn,New	York		
	21. Signature of Fuheral Service						nkins Funera			
	1	4-1-201					er, Maryland			
	23a Part 1 Enter the disease	or complications that caused the						Approximate		
	Shock, or heart failure./Li	st only one cause on each line.						Interval Between		
1	Immediate Cause (Final disease or condition	Atheros	clesot	ic CAN	dioVAS	culan	Heart Dis	Crisci and Dodgii		
	resulting in death)	Due to (or as a co	onsequence of):	,,,	-,01,13	(100)				
		b								
ē	Sequentially list conditions, if any, leading to immediate									
Examin	cause. Enter Underlying Cause (Disease or injury that initiated events									
xa	resulting in death) Last	Due to (or as a co								
응		d								
/Medical	IF FEMALE:									
	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy	1		23d. Date of deliv			
Physicia	1 ☐ Yes 2 ☐ No	4 Pregnant at time 9 Unknown	e of death 5	Other (specify)			Month	Day Year		
چ	9 Unknown	3C OTKTOWN								
by P	Part II. Other significant condi-	tions contributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	tobacco use contribute to t	the cause of death?		
						1 🗆	Yes 2 □ No 3 □ Pro	bably 4 DUnknown		
ete										
Completed						24a. Was auto	psy 24b. Were auto	opsy findings available empletion of cause of		
S							ormed? death? 2⊠ No 1 ☐ Yes	2⊠ No		
Be	25. Was case referred to medic examiner?	al			26. Place of De	ath (Check only	one)			
2	1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatien	nt 3 DOA Oth	er: 4 \(\sum \) Nursing I	Home 51√ Resi	dence 6 Other (Speci	fv)		
	27. Manner of Death	28a. Date of Injury	28b. Time of				how injury occurred	.,,		
100	1 Natural 5 Pend 2 Accident inves	ing (Month, Day Ye	ear) Injury		k? Yes 2∐No					
flca	3 ☐ Suicide 6 ☐ Could	not be	At home farm etc			28f Location (Street and Number or Run	al Route Number		
ertification:	4 - Homicide deter	wn, State)	a riode williber,							
O	00-0-17									
ca	(Check only 2 Medica	cause(s) and manner as s	stated.							
ed	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Certifier 29c. Certifier 29d. Certifier 29d. Date signed (Month. Day. Year.)									
Σ	29b. Signature and title of certifi		29d. Date signed (Month,	Day, Year)						
	falvader Alesta Do 140065927 Marco 14 200									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	Salvador Sy	Lvester M.D. 3	001 Hosp	ital Driv	e Chever	ly, Mary	land 20785			
State	31. Date filed (Month, Day, Yea	2 32. Registrar's	Signatura							
		I Make I								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ALBERT SMITH SR. 2007 larch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOCTORS COMMUNITY HOSPITAL PRINCE GEORGE LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 117 M 2□ F Yrs 70 Director 578-48-6302 11-30-1936 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show at items 23a or 28a-f sh ner must be notified PRINCE GEORG MD LANDOVER 1X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7708 PENNBROOK PLACE 20785 U.S.A. the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1**X** Yes 2 □ No If Yes, Give Year or D*a*tes: 1 Never Married Married "natural", or 1 ☐ Yes 21 No Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than PRIVATE Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER 11th marked other injury or other traumatic event, Ith and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RICHARD SMITH ELIZABETH GOUGH ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 pepartment of Health an Important: If Item 27 is any injury or other trau SUZANNE H. SMITH/WIFE 7708 PENNBROOK PLACE LANDOVER, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 3-20-2007 CHELTENHAM, MD 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition XXX /Medical Due to (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): burialphysician Physician/Medical the as attending IF FEMALE asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed een 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform 1∐ Yes CYCY 6 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendl 24 hours after death, Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 [FCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Box 68760. Records. Division or Vital

pe

mith, albert

Baltimore, Maryland 21215-0036

To the within 2

State Registrar

31. Date filed (Month, Day, Year)

80 Name and add

29b. Signature and title of certifier



29c. License number

UTCLC

29d. Date signed (Month, Day, Year)

ex CN, IM BOLIE MDZEAIS

			1 - For State Registrar	State of Ma	aryland		artment of r <i>tificate of</i>			, ,	giene Reg. No. 🤈 :	007	00000
Е	Physici	an	1. Decedent's Name (First, Middle, La	,						2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Sylvia Sil 4a. Facility Name (If not institution, qi				4b. City, Town,	or Locatio		March 8,		ty of Death	0.30
	Examir	ier	1801 E. Jefferson		431			kvill				tgomery	,
	Funeral				je (In yrs. la	st birthday)	If Under 1 Yea	r If Unc	ler 24 Hrs.	8. Date of Birt	h	9. Birthr	place (State or Foreign
	Director		081-01-2122	1 □ M 2 🖾 F	89	Yrs.	Months Days	Hour		(Month, Day November	28,1917	New New	York
	pu ,		Usual Residence of Decedent		Tan-City	Taum au La	antion						10111 11 01 11 11
	aryla show d at	_	10a. State 10b. County		Toc. City,	Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he M.	Director	Maryland Montgon	nery				ville			40 011	()17	
	with t		10e. Street and Number				10f. Zip Code				10g. Citizen o		ntry?
	s 23 must	eral	1801 E. Jeffers	12. Was Decedent		12.1		852	Origin? (Spor	offy Voc or No.		J.S.A. ace - Americ	can Indian
215-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show solical Examiner must be notifiled at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	•		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2x No			lican, etc.)	Spec	ack, White,	
ŏ	2 hou atura		15. Decedent's E	Education		16a. Dece	dent's Usual Occi	pation			16b. Kind of		
215	within 7 iene. than "n the Medi	Completed	(Specify only highest gas Elementary/Secondary (0-12)	ra <i>de completed)</i> College (1-4or 5	5+)	(Give life, l	kind of work don DO NOT use retir	ed) ed)	nost of workin	g			
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ng	should be filed within 72 ho nd Mental Hygiene. marked other than "natu matic event, the Medical	Be (17. Father's Name (First, Middle, Las	t)				18. Mc	other's Name	(First, Middle,	Maiden Surna	ame)	
yla	should be and Mental is marked c aumatic eve	၉	Hyman Beispiel							Schade!			
Maryland	S S S		19a. Informant's Name/Relationship	(Type. Print)	- 1		ng Address (Stree					, , ,	Code)
	is 1 and 2 of Health item 27 i	10	Robert A. Silverman	n - Son	20h Pis		Deborah I			te, Maryla			Ctata
altimore,	0 0 - L		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		ce.	metery, crei	osition (Name of matory or other pi	ace)		ale	20c. Location	i - City or To	own, State
Ħ	permit. Pag Department Important: I any injury c		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Loude		Crematory 2. Name and Add		3/12/2	2007	Baltimon	re, Mar	yland
Ba	permit. Pag Department Important: I any injury o	4 //3	Myelit.	14bet	/	H 1	ines-Rinal 1800 New F	di Fu lampsh	neral Ho ire Aver	ue, Silv	ver Sprin	ng, Mar	yland 20904
			23a. Part1. Enter the disease, or cor shock, or heart failure. List on	nplications that caused y one cause on each li	d the death. ine.	Do not ent	er the mode of dy	ring, such	as cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_aCocona	(0)	acted	J.50	A 56.					Oriset and Dealit
	/Medical Examiner		resulting in death)	Due to (or as	a c mseque	ence of):							_
1	LXuiiiiici	_	Sequentially list conditions,	b. Due to lor as	745	Mel	1 Jus						
	ted Isit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to joi as	a conse ₄ ue	erice ou.							
	and al-trar	хап	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):							
68760,	ficate be executed griphysician and is the burial-transit	<u>8</u>											
289	± 5 2	edical		G									
Box	The law requires that the death certif te has been signed by the attending tage 2 should be detached for use as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7				23d. D	ate of deliv	ery
	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 🖽 No	1□Live birth 4□Pregnant a			⊒Ectopic pregnan ☐Other <i>(specify)</i>	су			\ \	/lonth	Day Year
P.0	at the deby the stached	Physician/M	9 ☐ Unknown	9∐Unknown						-			
	res tha signed l	by P	Part II. Other significant conditions	contributing to death b	out not resul	ting in the u	nderlying cause g	iven in Pa	ırt I.	23e. Did to	obacco use co	ntribute to t	he cause of death?
ğ	w require been sig should b									1 🗆 \	∕es 2 No	3 ☐ Prol	bably 4 ⊠Honknown
ပ္ပ	e law re has be	plet								24a. Was			opsy findings available ompletion of cause of
or Vital Records,		Completed								perfo	rmed?	death?	2□No
/ita	an: rtific tor,	Be (25. Was case referred to medical examiner?					26. Pl	ace of Death	(Check only o			
7	hyslci his cer il direc	2	1 ☐ Yes 2 No			R/Outpatier	" OLI DOA		Nursing Hom	e 5 🗷 Resid	dence 6 □0	ther (Specia	fy)
		ü	27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Inju (Month, Da		28b. Time o Injury	W			8d. Describe h	now injury occi	urred	
Sio	Attending r death. ector; After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	ne -	4.11			Yes 2					
Division	- O -	Certification:	4 Homicide determined	Zoe. Flace of ing	tc. <i>(Specify)</i>		eet, factory, offic	9	2	Bf. Location (5 City or Tou	Street and Nun vn, State)	nber or Rura	al Route Number,
	pita urs eral		29a, Certifier 1X Certifying F	hyeiolan: To the heet	of my know	dedae deat	h occurred at the	time date	and place a	nd due to the	Cauca(a) and	manner ac c	atatad
	To the Hospital or within 24 hours aft To the Funeral Di completely filled in	Medical		hysician: To the best miner: On the basis o and manner st	of examinati	on and/or in	vestigation, in my	opinion,	death occurre	ed at the time,	date and place	e, an d due t	to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier			-	29c. Lice	nse numbe	er		29d. Date sigr	ned (Month,	Day, Year)
	7.		2 3 3.	Ve was			200	578	84		3/12/	2007	
•	V		30. Name and address of person who	completed cause of d	death (Item :	23a) (Type.			-7		, ,		
			Damien J. Doyle, M.	•	·		-	cville	, Maryla	and 2085	2		
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registr	rar's Signatu	ure	_						
8	Regist	ar	MAR 1 4 2	JU!	W A	C Ho							

07-01849		Please Type or Print in Black Indelible Ink.			jible.	
Stewart Winfiel		h State of Maryland / Department of H			g. No. 200	7 11986
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) STEWART W. SMITH	N	Date of Death Month	Day Year	3. Time of Death 0137 hrs
m of		4a. Facility Name (if not institution, give street and number) 4b. 0	ity, Town, or Location of Death	larch 9, 2	4c. County of Death	
			altimore	D-1- (D:4)	- 444 D D A A A A A A A	halas (Otalas
Funeral Director			lonths Dave Hours Min		19,1949 Got	1
á.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		rat,	エン・エンコー	
nd how ar	_	MD Anne Arundel Lau	rel			10d. Inside City Limits 1 Yes 2 XNo
Marylar 28a-f s d at on	Director	10e. Street and Number 10	f. Zip Code	10	g. Citizen of What Cour	-
ith the Maryland 23a or 28a-f show any notified at once.	Ë	3516 Spring Road	20724		U.S.A	
eath wi items ust be	Funeral	1 Never Married 2 Married Armed Forces? If Yes, s	cedent of Hispanic Origin? (Specify pecify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.)	14. Race - Americ White, etc.	can Indian, Black,
after d	by Fi	3 X Widowed 4 Divorced If Yes, Give Year 1 Yes	2 No specify:		Specify:	3lack
2 hours "natu	ted		sual Occupation (Give kind of work of working life. DO NOT use retired)	done	16b. Kind of Business/li Macke V	
036 vithin 7 ene. er than Medica	Completed	9th Co	oin Collector		Co	enaing
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name (First, Middle, Last) Harry Smith	18.Mother's Name (Firs Marga		aiden Surname) Powell	
212 ould be d Ment s mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	dress (Street and Number or Rural	Route Numb	per, City or Town, State,	
MD and 2 sh salth an em 27 i		Stewart Robertson (Son) 719 22 20a. Method of Disposition 20b. Place of Disposition	lst St, NE, Wa		gton, DC 2	
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	1	1 X Burial 2 Cremation 3 Removal from State crematory or other p			Laurel,	
Baltin permit. Pa Departmet importan njury or		21 Single of Funeral Septide Lice (ee 22. Name	and Address of Facility	VDEN 1	PUNERAL H	OME, P.A.
	1	246 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	N. Washingtor			11 - 12 12 12 12 12 12 12 12 12 12 12 12 12
Physician Wedical		failure. Light only one cause on each line.		piratory arres	st, snock, or neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiova Due to (or as a consequence of):	aculai Diacaac			
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause : Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
ecuted and transit		d.				
1760, ficate be execute g physician and the burial - tran	fedic	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Ox 6876 ath certifica attending ph	ian/N	23b. Was decedent pregnant in the past 12 months?	eath 3 Ectopic pregnancy			ay Year
Box 68760 c death certificate b the attending physic dofor use as the bu	Physician/Medical	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other 9 Unknown	(Specify)		6	
P.O. B that the do	by Pt	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		pacco use contribute to t	
ords, P.C w requires that is been signed is	ted	Chronic obstructive pulmonary disease		1 Yes		opsy findings available
Division of Vital Records, P.O. rate of the law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed			autops	y prior to c ned? death?	ompletion of cause of
Vital Rec ysician: The I his certificate I director, page	o l	25. Was case referred to medical	26.Place of Death (Check only	1 Yes 2 one)	No 1 ✓ Ye	s 2 No
F Vits	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	DOA Other Nursing Ho		Residence 6 Other	
ivision of a strending Phaffer death. Director: After to in by the funeral	Certification:	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	. Describe no	ow injury occurred	
Visic or Atte or Atte or Atte or Atte or Atte or Atte	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	ctory, office building, etc. 28f.	Location (St or Town, Sta	treet and Number or Run	al Route Number, City
Di Hospital o 24 hours a Funeral I tely filled	Cer	4 Homicide determined (Specify) 29a. Certifier	at the time data and along and			d
Division of Vital Records, P.O. Box 68760, To the Hospiral or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—tra	edical	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.				
4	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor.	th, Day, Year)
			O.C.M.E.		March 9, 2007	

State 31. Date filed (Month Co. Year) 2007
Registrar

gistrar's Signatur

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month March 2 ou **Physician** Jambur 1:55 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ba Paltis re Under 1 Year | If Under If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex Social Security Number () 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 085-40-130 1 □ M 2 1947 ŃΥ Director December 5. Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 United States 9317 Crimson Leaf Terrace Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 and 2 should be filed within 72 hours after whealth and Mental Hygiene. In 27 is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🟋 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvia Rubin George Bossowick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trau 9317 Crimson Leaf Terrace Potomac MD 20854 Marvin R. Sambur - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Judean Memorial
Gardens 20a Method of Disposition 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 3/11/2007 Olney, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilitEdward Sagel Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Cascin **Physician** /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has page 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 → 10 1 Inpatient ဥ 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred il or Attending F after death. Certification: 1 Atural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl) one) 29b. Signature and title of certifier

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State Registrar 31. Date filed (Month, Day, Year)

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and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Nyusga Sapozhnikova 2007 12:50 A M March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth June 8, 1921 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 85 215-35-4048 Director Ukraine Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show ms 23a or 28a-f shov must be notified at Y⊟Yes 2 No Director Maryland | Rockville Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5529 Halpine Place, # 102 20851 U.S. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: 2 White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any linity or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isaac Sheftel Leah Chepovetskaya ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20855 Irina Knizhnik - Daughter 7101 Grinnell Drive, Derwood, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Gardens 3/13/2007 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction,
1091 Rockville Pike, Rockville, 21. Signature of Funeral Service License Inc. Maryland Oonald 20852 23a. Part1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEART FAILURE ONGESTIVE DAYS /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION 3 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed AORTIC STENOSIS MONTMS burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 3 DAYS URDSEPS15 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2**≥**€ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed?
1□ Yes 2■No 24b. Were autopsy findings available prior to completion of cause of death? cate has certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ျ After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending I nin 24 hours after death. Certification: 5 ☐ Pending investigation Natural
Accident Injury within 24 hours are: constraint 24 hours are: To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3
☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 12, 2007 M.P. 00064444 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arijit Dasgupta 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year)

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Registrar

or Attending Physician: The law requires that the death certificate be executed O. Box 68760 م Records. Division of Vital To the Hospitel within 24 hours e To the Funeral I completely filled

Physician

/Medical

Examiner

Funeral

Director

r then "natural", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if tem 27 ie marked other in any injury or other trainment.

Physician

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Immediate Cause (Finaf disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed Be 25. Was case referred to medical examiner? 1 Yes 2 XNo 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0047330 MARCH 11, 2007 swowns

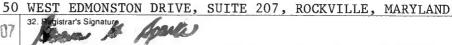
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State Registrar

31. Date filed (Month, Day, Year) MAR 1 4 2007

DR. THOMAS JOSEPH,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar	State of N	narylan	-		of Health a <i>of Death</i>	nd Mei		di ten	UU/	09867
			Decedent's Name (First, Mid-	die, Last)			imouto	OI DOUIII	2.	Date of Deat	ng. No. h		3. Time of Death
	Physici		LILY MAR	SIE STE	XT.C	KIF	R		m	Month 1.43CH	Day 10	Year 200=	1 1310 M
4	/Medic Examir		4a. Facility Name (If not instituti			, 17LL	Y	wn, or Location of		MUCH		unty of Deatl	
	1104-		UNIVERSITY OF M			CENTER last birthday)		OALTIY				NIA	Chata as Faraira
	Funeral Director		218-77-8558	1 M 2 XF	ige (in yrs.	Yrs.		ays Hours	Min. F€	Date of Birth (Month, Day, 2b. 16	2007	Co	nplace (State or Foreign untry) Tyland
	land ow		Usual Residence of Decedent 10a. State 10b. Count	dy	10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Mary feb	ţō	MD Har	ford	F	Edgewoo	bc						1 ∐ Yes ZXXNo
	r 28a	Director	10e. Street and Number				10f. Zip Co	ode		1	0g. Citizer	of What Co	untry?
	h with	O E	2010 Cherry Ro	ad			210	40			Unit	ed Sta	ites
	death	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	.S. 13.	Was Deceden	t of Hispanic Orig Cuban, Mexican,	in? (Specify	y Yes or No-	14.	Race - Ame	rican Indian,
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Ie marked other then "natural", or Iteme 23a or 28a-f ehow aumatic event, the Medical Examiner must be notified at	þ	1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	ar <i>ri</i> ed 1 ⊡Yes 2.1∑ tfYes Give	No	1	1 Tes, speciny		, Puerto Hic	an, etc.)	1	Black, White ecify: V	nhite
2-0	72 hc natur	eted	15. Decede	ent's Education lest grade completed)		16a. Dece	dent's Usual C	occupation	ol working		16b. Kind	of Business/l	industry
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anc	ould be fi Mental F arked ot atic ever	Be	17. Father's Name (First, Middle	_	-1			_		īirst, Middle, Λ			
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<u>s</u>	d 2 s th an th an traur	7 2	Dawn Marie Str					treet and Number			•	0wn, State, 2 1040	ip Code)
ė,	1 en Heal em 2	(8)	20a. Method of Disposition	ickiei, moti	20b. F	Place of Dispo	sition (Name	y Road,	Date	-		ion - City or	Town, State
Baltimore,	permit. Pages 1 end 2 should be Deperment of Health and Menia Important: If Item 27 Ie marked any Injury or other traumatic es ance.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specify)	9	ıthern	matory or othe Mem Gr	dns (-2007 [,	
Ba	permit Deper Impor eny In		21. Signature of Funeral Service	e Licensee	v_	22		ddress of Facility Funeral		e, PA	Owin	gs, MI	20736
			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that cause st only one cause on each	ed the deat	h. Do not ent	er the mode o	f dying, such as c	cardiac or re	spiratory arre	est,		Approximate Interval Between
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	/Medical		resulting in death)	Due to (or a									50 minores
	Examiner	_	Sequentially list conditions,	b. CYANO	TIC	CON	GENT	TAL H	EART	DE	FFEC	7.	
	pe #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	uence of):							
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ХОЯ			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregna						23d	. Date of deli	verv
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1☐Live birth 4☐Pregnant			∃Ectopic pregr ∃ Other <i>(speci</i>					Month	Day Year
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ပ္ပ	law require as been si 2 should t	Completed								24a. Was ar	n 2	4b. Were au	topsy findings available completion of cause of
	The li	E O								autops perform	y ned? 2X No	death?	completion of cause of 2□ No
Zig		BeC	25. Was case referred to medic	al				26. Place	of Death (C	1 ☐ Yes 2	/-	1 🗆 1 63	2010
-	nysic nis ce direc	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	ient 2 🗆	ER/Outpatier	t 3 DOA	Other		5 🗌 Reside		Other (Spec	cify)
n o	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pend	28a. Date of In (Month, D	jury ay Year)	28b. Time o Injury	f 28c.	Injury at Work?	28d	l. Describe ho	w injury o	ccurred	
<u>0</u>	Attendi death. ctor: A y the fu	cati		tigation			М	1 ☐ Yes 2 ☐ N	lo				
DIVISION	Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certification by the funeral director, telly filled in by the funeral director,	Certification;		mined 28e. Place of Ir building, e	njury - At ho etc. <i>(Specif</i>)	ome, farm, str y)	eet, factory, o	fice	28f.	Location (Sti City or Town		lumber or Ru	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medicai (29a. Certifier 1 Certify (Check only 2 Medical	ing Physician: To the bes il Examiner: On the basis and manner s	of examina	wledge, death tion and/or in	n occurred at t vestigation, in	he time, date and my opinion, death	place, and h occurred a	I due to the ca at the time, da	use(s) and ate and pla	d manner as ace, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certif				29c. L	cense number		29	9d. Date si	igned (Month	n, Day, Year)
1	-		1 Molinia	1.	35	Physi	AU	417643	35/15	793	Mara	6 10	2007
	ı		30. Name and address of perso	who completed cause of	death (Item		Print)		- J bo J		164 6	10	, ~~ ,
	1		JOCELYN A. L	EWIS D.O.	22	SOUTH	1 GRE	ENE S	STRE	FET P	SALTI	MORE	MD. 21201
4	Sta		31. Date filed (Month, Day, Yea	32. Regis	tras Signa	ture	Anne	20					,
8	Registr	ar	MAI	K I'M COOLLY	SER OFF	9	And the second	8					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Charles William Skinner **Physician** 8:45 A March 10 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3690 Broomes Island Road Calvert Port Republic If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 □ F Hours Director 215-18-0432 88 Dec 19 1918 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director Maryland Calvert Port Republic 1 Yes 2 No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 3690 Broomes Island Road 20676 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: ₩ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) agriculture/ construction farmer/ carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Charles Wesley Skinner Jessie Marion Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie Joy- daughter 4390 Ball Rd. Port Republic MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other plasmarch 14 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Episcopal Church Cemetery Port Republic Maryland 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Juneral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CHF /Medical Due to (or as a consequence of): Examiner Acute Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed atrial Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Pul Physician/Medical *+1/0* 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 110 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only,one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd.

Shul

29b. Signature and title of certifier

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MD

Shah, MD Hospital
32. Registres Signature Prince Frederick MD 20678 31. Date filed (Month, Day, Year) MAR 1 3 2007

State

Registrar

29c. License number

D50290

29d. Date signed (Month, Day, Year) 3-12-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar	State of Maryla		rtificate of D			Reg. No.	007	09869
	Physici		1. Decedent's Name (First, Middle, La. Wardell C.	Smith				2. Date of Dea Month March	Day	2007	3. Time of Death
	/Medic Éxamin	now!	4a. Facility Name (If not institution, give			4b. City, Town, or L	ocation of Death	Haren		ounty of Death	1343
<u> </u>			Holy Cross Hosp		- Control to 1	Silver :	Spring If Under 24 Hrs.	0.5.4.4.6.4		ntgomer	-
	Funeral Director		5. Social Security Number 6. S 578-74-9681 1 Usual Residence of Decedent	ex X M 2□F 52	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 09-24-	y, Year)	Cour	place (State or Foreign atry)
land	ow		10a, State 10b, County	10c.	City, Town or Lo	ocation				1	0d. Inside City Limits
e Man	la-f sh tiffed	ctor	Maryland Montgome	ry	Kε	ensington					1X Yes 2 □ No
th with th	23a or 28 ust be no	Funeral Director	10e. Street and Number 3000 McComas Aven	ue		10f. Zip Code 2089.	5		10g, Citizer U	of What Cour	ntry?
-UU36 hours after death with the Maryland	ital Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	6	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 █ No		ecify Yes or No- Rican, etc.)		Race - Americ Black, White, becify: B1a	etc.
2-C	natura dical E	eted	15. Decedent's Ec (Specify only highest gra	ducation de completed)	16a. Dece	dent's Usual Occupat	ion Iring most of worki	na	16b. Kind	of Business/In	dustry
21215-0036 d within 72 hours af	ntal Hygiene. ed other than "natu: event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done du DO NOT use retired) urity Offi			Easte:	rn Shie	elds
	other ent, th	Be Co	17. Father's Name (First, Middle, Last,	1	Dece		18. Mother's Name				
/lan vuld be		To B	Sylvester O. Smit	h, Sr.			Marietta	-			
= p	f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Patricia A. Smith		19b. Maili 6414 Washi	ng Address <i>(Street ar</i> North Cap ington, D.	nd Number or Rura itol Str C. 20012	eet, N.	er, City or To W •	own, State, Zip	Code)
ore, es ta	of Health a If item 27 Is or other trau		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	o. Place of Dispo cemetery, cre	osition (Name of matory or other place,))ate		tion - City or To	
Baltimore, Jermit. Pages 1 a	rtment rtant: I		4 □ Donation 5 □ Other (Specification)	y) G		Cemetery 2. Name and Address		6-2007		hington	
	Department of Important: If it any Injury or conce.		21. Signature of Funeral Service Licer	Bacon Co		2. Name and Address 3447 14th					
	100		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.	eath. Do not en	ter the mode of dying,	, such as cardiac o	or respiratory a	rest,		Approximate Interval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Due to (or as a cons		System Fa	ilure				
E	xaminer		Szavoztiallu fut acaditives	b Terminal	•	d Immune	Disease	Syndr	ome		
pe	ısit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):						
U, execut	ın and ial-trar	Exan	that initiated events resulting in death) Last	C. Due to (or as a cons	sequence of):	· · · · · · · · · · · · · · · · · · ·					
68/60 , tificate be executed	physicia the bur	edical		_d							
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre					230	I. Date of delive	erv
ords, P.O. Box requires that the death cer	ied by the attending physician and detached for use as the burial-transit	hysician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□F 4□Pregnant at time o 9□Unknown		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>				Month	Day Year
s that	ned by e deta	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying cause given	ı in Part I.	23e. Did to	obacco use	contribute to the	he cause of death?
ord equire	should be							1 🗆 ነ	res 2□1	No 3 ☐ Prot	pably 4 Mau Unknown
The law	ate has b page 2 s	Completed						24a. Was autor perfo 1 Yes	an 2 ssy rmed? 2 X No	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available impletion of cause of 2 XNo
Or Vital Physician:	is certific director,	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Death				
Phys Q	ral di	7 :T	1 ☐ Yes 2 📉 No 27. Manner of Death	28a. Date of Injury	ER/Outpaties 28b. Time o	of 28c. Injury	at Nursing Hol	me 5 Residence Reside Residence Resi			(y)
DIVISION I or Attending	death. ctor: After thi y the funeral o	cation	1 🖾 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				es 2□No	206 Leasting (74	to make a second	1 San An Alexander
5 6	fter Direction by	Certification:	4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Spe	ecify)	reet, factory, office		City or Tov	vn, State)	umber or Hura	al Route Number,
L e Hospital	Eun Fun	Medical		nysician: To the best of my niner: On the basis of exam and manner stated.							
To the	To the comple	Me	29b. Signature and title of certifier	1		29c. License				signed (Month,	Day, Year)
^			1 July	renn	, MD	D0065			03/12		2
21	3		30. Name and address of person who	completed cause of death (I	Gahle.	Rulge To	Env.#C	Kock	ville	Ma	20950
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnatue						-

State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:25AM /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Holly Place Hagerstown polace (State or Foreign untry) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 M 2 F Yrs. 79 Oct.19,1927 Maryland 212-24-6675 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County or 28a-1 show in then "natural", or itema 23a or 28a-1 show the Madical Examination with be notified at 1)CXYes 2 □ No Director Washington Hagerstown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funerai 21740 LISA 31 North Locust Street filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Insurance Company 12 Clerk it of Health and Mental Hyg If item 27 Is marked other or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Edward Mole Scott Zoe Ellen Mellott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Moats - Sister 116 W. Potomac St. Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Dopartion 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Cedar Lawn Mem. Park Mar. 21, 2007 Hagerstown, Maryland 21. Signiture Funeral Se see Osborne Tuneral Home, P.A. 425 S. Conococheague St. Williamsport, Maryland Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat ements A Pors **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Qualto (or as a nonsequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached to 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 4 Unknown 1 Yes 2 No 3 Probably been si 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only Other 4 Nursing Home 5 esidence 6 Other (Specify) 1 🗌 Yes ပ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how intury occurred 28b. Time of Certification: 1 atural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Chack only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056783 March 18, 2007 15/1m eath (Jem 23a) (Type, Print) ed cause of 023 11110 Medical Campus Rd. Hagerstown, Maryland 31. Date filed (Mo 32. Redistrar's Signature 19 State Registrar

		1 - For State Registrar		State of Ma		Depa	rtment		h and M		/giene	200	e. 7	0987
Physic		Verlee			5					March	Da	^y 2007 ^Y	ear	10:00а м
/Medi Exami		4a. Facility Name (If		re street and number)				own, or Locati			1	. County of		rges
Funeral Director		5. Social Security Nu 250-48-9	471 6.5		je (In yrs. last b	oirthday) Yrs.	If Under 1 Months	Year If Un Days Hou	der 24 Hrs. Irs Min.	8. Date of Bi (Month, D July 2	irth av Year 18, I	934 K	Birthpla Countr ings	burg, S.C
Aaryland Febow	ŏ	Usual Residence of 10a. State	10b. County		10c. City, To		cation						10	d. Inside City Limits
r 28a-	rect	Florida 10e. Street and Nurr	ber		Jaci	CSOII	10f. Zip 0	Code			10g. Ci	tizen of Wh	at Counti	y?
th with	ai D	216 W. 21	st. Stre	et			922	206			Ü	Inited	Sta	tes
d 21215-UU36 filled within 72 hours after deeth with the Maryland Hygiene ther then "naturel", or Iteme 23a or 28a-1 show ont, the Medical Examinat must be trudified at	by Funeral Director	11. Marital Status 1 □ Never Marrie 3 ☑ Widowed	_	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			Vas Decede Yes, specif			ecify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:	America White, e B1a	tc.
D-C	eted	(Speci	15. Decedent's E	ducation ade completed)	16	a. Deced	ent's Usual kind of work	Occupation done during in retired)	most of works	ng	16b. K	(ind of Busin	ness/Indu	ıstry
Mithin Mithin	Completed	Elementary/Secon		College (1-4or	5+)		oo not use cher	retired)			F	Educat	ion	
il Hygie other t	ပိ	17. Father's Name (First, Middle, Last	4			CHEL	18. M	other's Name	(First, Middle				
<u> </u>	To Be	Calvin L	egette					Q.	allie V	Jileon				
aryla should and Men marke	-	19a. Informant's Na		Type, Print)	19	b. Mailin	g Address (I Route Numb	ber, City	or Town, St	ate, Zip (Code)
C - M P		Janie F.	Reeder	/ Sister						ashingt			2074	
or the last of the				Removal from State	20b. Place cemet Dev		sition (Name natory or oth on Gai		3/17/	² 2007		ocation - Ci lins,		
Baltimo permit. Page Department of Important: if any Injury or		21. Signature Fur	neral Service Lice	nsee				Address of F						-
Physician /Medical Examiner	Examiner	23a. Part Enter the shock, or hear Immediate Cause (I disease or condition resulting in death) Sequentially list confirm any, leading to imcause. Enter Under Cause (Disease or that initiated events resulting in death)	Final Inditions, mediate tying njury	b. Due to (or as	d the death. Do	e of):		of dying, such		e/Fores		le, M		20747 Approximate Interval Between Onset and Death Months
BOX 68/	Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	menths?	d	2 Fetal dea		Ectopic pre					23d. Date o Month		y Day Year
COTGS, P.O. I	þ	Part II. Other signifi	cant conditions	contributing to death b	out not resulting	in the un	nderlying ca	use given in P	art I.		tobacco Yes 2			cause of death?
	Completed									24a. Wa auto peri 1 🗆 Yes	opsy formed?	pridea		sy findings available pletion of cause of
VITC iclan certifi ector	Be	25. Was case referr examiner?		Hospital:				Othor		Check only		. /		Sieteric
n of ng Phy Mer this Jneral d	ation: To	1 Yes 2 27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of Inju (Month, Da	ent 2 ER/C ury 28b uy Year) 28b	Time of Injury		dc. Injury at Work?		me 5 Res 28d. Describe		6 Other ary occurred		resilence
DIVISIC DIVISIC tal or Attend rs efter death al Director: ,	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of in	jury - At home, tc. <i>(Specify)</i>	farm, stre	eet, factory,	office		28f. Location City or To			or Rural	Route Number,
DIVISIO To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the f	Medical	one)	2 Medical Exa	hysician: To the best minar: On the basis o and manner st	of examination a	ge, death and/or inv	estigation, i	in my opinion,	death occurr	and due to the ed at the time	, date an	d place, and	d due to	the cause(s)
To To con	2	29b. Signature and	time of certifier	and Dame	Pthys	CIA	7	D 535	90		MAI			2007
_(5)		54PHE	4 04	1	DOM GO	9	Print) (BALT	NETIMOR	SROAD E A	ND	7 212	05	
St Regist	ate	31. Date filed (Mont	h, Day, Year)	32. Registr	rar's Signature	M	7							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Patsv Ann Startzman March 2007 4:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2**X**□(F Yrs. 69 Mary Land 16,1938 Director 214-34-2300 Jan. Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo West Virginia Berkeley Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r Funeral 91 Harbor Court 25419 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 🙀 No Completed by Specify: 3€XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cager Mail Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental Hem 27 Is marked out Be George Edward Teach Anna May Guessford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ! If item 27 I <u> Steven Startzman - Son</u> 12431 Mummert Rd. Clear Spring, Maryland 21722 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important; If any injury or 4 Donation 5 Dother (Specify) Greenlawn Mem. Park Mar.20,2007 Williamsport, Maryland 21. Signare of Juneral Services Icen OSBOPAWAPUREFERING Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Michastatic cancer alakacwa origi /Medical Due to (or as a consequence of): Examiner ulmoray Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2i☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate Physiclan: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 LNo 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 🖸 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D62588 M

CZ 5

Registrar
DHMH 17 Rev 1/2001

E Antre tam St, Itageshown, MM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBAO

31. Date filed (Month, Day, Year)

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2007 ▶

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32. Registraris Signature

		1 - State Registrar	Olato (of Maryland / D	Certificate of			- U U I	098/3
		Decedent's Name (First, Midd	le, Last)				2. Date of Death		3. Time of Death
Physi		George Edwa	rd Smith				Month March	Day Year 11. 2007	11:40 AM
/Med Exam		4a. Facility Name (If not institution		umber)	4b. City, Town, o	r Location of Death		4c. County of Death	111.40 All
		Union Hospital	of Cecil	County	E1kto	n		Ceci1	
Funera Directo		5. Social Security Number 213–36–9440	6. Sex 1 🖾 M 2 🗆 F	7. Age (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	9. Birthy Court 3,1940 Penn	
pu ,		Usuat Residence of Decedent		140.00					
aryla shov	<u>_</u>	10a. State 10b. County	/	10c. City, Towr	or Location				10d. tnside City Limits 11 Yes 2 □ No
he M	ecto	Maryland Cec	<u>i1</u>	North					
with a or 3	吉	10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	,
eath	era	207 South Mai:		cedent Ever in U.S.	21901	lienanio Origin? /Sn		United STat	
15-UU36 72 hours after death with the Maryland *natural; or items 23a or 28a-f ahow adjest Examiner must be notified at	by Funeral Director	1 Never Married 2 Mar 3 ₩ Widowed 4 Divorced	ried Armed F	orces? 2□No Army ive	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, White,	etc.
215-UU36 thin 72 hours aff e. an "natural", or	ed		nt's Education	Dates: 1963-65	Decedent's Usual Occup	ation	11	6b. Kind of Business/In	voteub
within 72 ene.	Completed		est grade completed)	(Give kind of work done life. DO NOT use retired	during most of work	ing	ob. (tille of basiliose)	dustry
F 3 6 € 2	E	12	College	(1-4or 5+)	Carpenter		1	U.S. Govern	ment
e filed other vant, tr	BeC	17. Father's Name (First, Middle,	Last)			18. Mother's Nam	e (First, Middle, Ma		micric
VIOLE DE VIO	To E	Chalmer W. Sm	ith			Doroth	y Pearl N	Miller	
Maryland d 2 should be file th and Mental Hy ?? Is marked oth traumatic avant		19a. Informant's Name/Relations			Mailing Address (Street				
C = 14 F		Christina C.	Smith / Da	aughter 30	0 Old Farmi	ngton Roa	d, North	East, Mary	land 21901
Baltimore , permit. Pages 1 are Department of Heal mportent: If Item		20a. Method of Disposition • 1XXBurial 2 ☐ Cremation	3 DRemoval from	cometer	Disposition (Name of y, crematory or other place	э) Mar	Date 20 Ch	Oc. Location - City or To	own, State
Pages ment of ent: If It		4 Donation 5 Other (5	Specify)		ank Cemeter	y 16,	2007 Ri	ising Sun,	Maryland
Baltimor permit. Pages Department of Importent: If Its any Injury or o	į	21. Signature of Fundral Service	Licensia		22. Name and Addre			neral Home	
m 4054	×	(MIN)							yland 2190
Physician		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Finat	t only one cause on		SPIRATORY				Approximate Interval Between Onset and Death
/Medica	_	disease or condition resulting in death)	aDue to	(or as a consequence of		אונוט	C13 27100	MOME (inknown
Examine			I MI	ULTTORC-	AN DYSE	UNICTION	.)		
	Je .	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence of					
cate be executed physicien and the burial-transit	Examin	Cause (Disease or injury			n j.				
bu , be execut icien and burial-tran	Ä	that initiated events	d	CPS 15					
cate be e		that initiated events resulting in death) Last	c. Due to	(or as a consequence of					
20 @ € \=	lcal	that initiated events	cDue to	(or as a consequence of					
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Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Courtal

Fruit Teland, De 19944

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1207

32. Registrar's Signature

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No.	0937
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	Time of Death 0653 hrs
and Examiner	SINAIDA SHKAPENKO March 12, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1101 S. Schumaker Drive, Apt. 105 Salisbury Wicomico	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthpla	ace (State or
the Maryland a or 28a-f show any tified at once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. MARYLAND WICOMICO SALISBURY 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	d. Inside City Limits XYes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho r other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11.01 SOUTH SCHUMAKER DRIVE, APT. 105 21804 USA 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced or Dates: 1 Yes 2 No	ГE
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exam Completed It	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BOOKKEEPER 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSURANCE	•
21215-0036 Juld be filed within 7 Marked other than merked other than the event, the Medica for Be Comple	17. Father's Name (First, Middle, Last) UNKNOWN 18 Mother's Name (First, Middle, Maiden Surname) ERIKA DOROGINIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	Code)
e, MD 21 and 2 should Health and Me item 27 is ma traumatic ev	IRENE KORDICK/DAUGHTER 100 BRENTWOOD CIRCLE, POCOMOKE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Tow	21851
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med To Be Comp	Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Constitute 5 Other Specify: CREMATORY OF DELMARVA 3/14/07 DELMAR, DEI 21. ign. r of Funeral Service Liu insee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE.	
Physician /Medical Examiner	23a. Fert I. Ent. r the disease, or complication, that the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart.	approximate Interval Between Onset and Death
outed transit I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	
ie be executi ysician and burial - trat	d. UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
box 68760, the death certificate be exuply the attending physician ched for use as the burial Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Other (Specify) 9 Unknown 9 Unknown	Year
ds, P.O. equires that the een signed by ould be detach		y 4 Unknown
Il Records, in: The law requires trifficate has been signor, page 2 should be Completed	autopsy prior to comp performed? 1 ✓ Yes 2 No 1 ✓ Yes 25. Was case referred to medical 26.Place of Death (Check only one)	oletion of cause of
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans edical Certification: To Be Completed by Physician/Medical E	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other: Soc 27. Manner of Death 1 Natural 5 Pending FOUND: Day, Year) 1 Natural 5 Pending Mar 12, 2007 Mar 21, 2007	ene
Division o vite the flospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune edical Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1101 S. Schumaker Drive, Apt. 105, Sa	
To the Hos within 24 h Completely	Z9a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, in the cause of the cau	
	30. Name and address of person who completed cause of death (Item 23a) 25. Exclusive Hallow O.C.M.E. March 13, 2007	

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year)
Registrar MAR 1 5 200

ORIGINAL

Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

			For State Registrar	State of Man		partment of Fertificate of			giene	07	0987	16
8	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea	ath Day	Year	3. Time of D	eath
5	Physici /Medio		Mark	J.	Spa	alding		03	23	2007	7:25	$\mathbf{A}^{\!\!M}$
	Examir	er	4a. Facility Name (If not institution, give Carroll Hospit	al Center		Westm:	r Location of Death inster		Car	ty of Death		
	Funeral Director		5. Social Security Number 6. S 205-22-4611	ex 7. Age (/ G√M 2□F	n yrs. last birthda 77 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	v. Year)		ace (State or F try)	
	A		Usual Residence of Decedent					06-29-	1929	Penr	ısylva	nıa
	anylan show	<u>.</u>	10a. State 10b. County		Oc. City, Town or	Location				16	Od. Inside City	- 1
	Ba-f s	Director		ams	Getty	sburg					1 □XYes 2	∐ No
	with t	Dir	10e. Street and Number			10f. Zip Code	L7325		10g. Citizen o		try?	
	death	Funeral	744 Sunset Ave	nue 12. Was Decedent Eve	er in U.S. 13		_	pecify Yes or No-	14. Ra	USA	an Indian.	
9	or iter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		I. Was Decedent of H If Yes, specify Cuba		Rican, etc.)		ack, White,		
003	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itema 23e or 28e-f show event, the Madical Exeminer i. ust be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 194	6-1952	1 ☐ Yes 2 🛣 No	Specify:		Spec	white		
<u>7</u>	n 72 h "nati	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usual Occup re kind of work done o DO NOT use retired	ation during most of world	king	16b. Kind of Wast	Business/Ind e Wat	lustry e r	
212	with jene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		ervisor	•/		Trea	tment	Plan	t
פַ	al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)		-		18. Mother's Nam	ie (First, Middle,	Maiden Suma	ımə)		
<u>Na</u>	should be ind Mental marked o	ToE	Harry Spa	lding			B	ernice	Co11:	inc		
Nar	12 shunand raum		19a. Informant's Name/Relationship (7	,, ,		ling Address (Street	and Number or Rui	rai Route Numbe	r, City or Tow	n, State, Zip	Code)	
o,	pes 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. If Item 27 is marked other than "natural", or itema 23a or 28a-f show are traumette event, the Madical Exempler must be notified at		Nancy A. Spald 20a. Method of Disposition		20b. Place of Disi	Sunset		Gettys	burg,	Pa.	17325	
o E	ages ent of nt: If II		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, ci	ematory or other place				•		
Baltimore, Maryland 21215-0036	permit. Pages Department of Himportant: If Ite any injury or of once.		21. Signature of Funeral Service Licen		Evergr	een Ceme 22. Name and Addres	tery 3- ss of Facility	28 - 07 L	Getty:	sburg	, Pa.	
<u> </u>	89 5 8 8		I fly to	Davie		Jeffrey L. D				bury Av	e Smiths	burg,
			23a. Part1. Exer the disease, or companies shock, or heart failure. List only	olications that caused the	e death. Do not e	nter the mode of dyin	g, such as cardiac	or respiratory ari	rest,		Approximate Interval Betwee Onset and De	
W. Age	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a USUL	MM	Mas 1	News	(1/1/1)	~		Oliset and De	a(III
387	Examiner		(Due to (or as a co	onsequence of):	rolms to	10-	1/2000	12			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (of as a co	onsequence of)	Minn-dil	t -u) CO 1/01	V() (
	rcuted nd transit	Examiner	that initiated events	c		,						
. 60	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a co	onsequence of):							
687	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the bunal-transit	dicai	•	d								
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	death	icia	in the past 12 months? 1 Yes 2 No	1☐Live birth 2 ☐ 4☐Pregnant at tim		☐Ectopic pregnancy ☐ Other (specify)					Day Ye	ar
<u>.</u>	at the de d by the stached	Phys	9 Unknowh	9□Unknown								
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Records,	v requ	etec						1 🗆 Y				
Ř	The lav	Completed						24a. Was a autop: perfor	sy me ≢ ?	prior to con death?	ssy findings av npletion of cau	se of
Vita		0	25. Was case referred to medical				26. Place of Deat	1 Tes	2/2 No	1 Tyes	2 □ No	
	nysici nis cer direc	ToB	examiner? 1 Tes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatio	ent 3 DOA Othe	250	ome 5 Resid		her (Specify	.)	
0	ing Ph Mter th uneral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time Injury	of 28c. Injury Work		28d. Describe h				
Sio	Attending P death. ctor: After y the funera	Icati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	201 1 1				
Division of	after d Direct Jin by I	Certificati	4 Homicide determined	28e. Place of Injury building, etc. (3	At nome, tarm, s Specify)	treet, factory, office		281. Location (S City or Town	n, State)	iber or Rural	Route Numbe	Уг.
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 12 Certifying Phy	sician: To the best of m	ny knowledge, dea	th occurred at the time	ne, date and place,	and due to the c	ause(s) and n	nanner as sta	ated.	
	To the Ho within 24 To the Fu completel	edical	(Check only 2 Medical Exam	iner: On the basis of exa and manner stated	amination and/or i	nvestigation, in my op	pinion, death occur	red at the time, d	late and place	, and due to	the cause(s)	
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certi∮ier			29c. License	-	2	29d. Date sign	ed (Month, L	Day, Year)	
		}				D62	100		03/2	23/6	7.1	
	8		30. Name and address of person whele	ompleted cause of death	(Item 23a) Type	ntor CH	root IN	ctmin	cter	LIN	2115	7
	Sta	te	31. Cate filed (Month, Day, Year)	32. Figistrar's	Signature	11 L 311	11	CSIIIIII	3101	140	٠,,٠	
	Registr	ar.	MAR 2 8/2	007 Status	1 St /	CONCE !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Pear MARCH **Physician** 14 6:30 AM MILDRED PATRICIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WASHINGTON 6030 CLEVELANDTOWN ROAD **BOONSBORO** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F 1934 MARYLAND 30, **Director** 214-32-4815 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Hean 27 Is marked there than "natural"; or Items 23a or 28a-f show any injury or other tranmatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛛 No Director **BOONSBORO** MARYLAND WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21713 U.S.A. 6030 CLEVELANDTOWN ROAD Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritai Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FINANCIAL INSTITUTION DATA ENTRY OPERATOR 12 Pages 1 and 2 should be filed venent of Health and Mental Hygie int: If Item 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHARLES ERNEST WILLARD HERMA ELIZABETH REEDER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6030 CLEVELANDTOWN ROAD, BOONSBORO, MD 21713 JEFFREY L. SMITH/SON altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/17/2007 **BOONSBORO CEMETERY** BOONSBORO, MARYLAND 21. Sign sture of F 22. Name and Address of Facility neral Service Licentee 7606 Old National Pike BAST FUNERAL HOME Paul m. Dean Boonsboro, Maryland 21713 Enter the disease Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Atheroschoulic Immediate Cause (Final disease or condition resulting in death) Physician (0100 /Medical Duy to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to him adult cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed the burial-transit and Due to (or as a consequence of) P.O. Box 68760, physiciar Physician/Medical use as t IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 ☐ Other (specify) signed by the a 9☐Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🍑 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes No death? 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined finder

Division or Vital Records,

after death completely filled in by the ne Hospital or A 124 hours after ne Funeral Dire To the within 2

34-8

Registrar

DHMH 17 Rev 1/2001

Medical

State

31. Date filed (Month, Day, Year) MAR 16 2007

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STEPHEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Korett, mo 32. Registrar's Signature

251

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

000056965

29d. Date signed (Month, Day, Year)

Records, P.O. Box 68760. **Division or Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 I H fulmony Piscase 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 MER/Outpatient 3 □ DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 🚅 artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 X Yes 2 No

12:51 PM

Year

14. Race - American Indian

White

Black, White, etc.

Specify:

2001

03H-7 State Registrar

6 OPAL Wa seem

31. Date filed (Month, Day, Year) MAR 15

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

D52323

Hagerstown Maryland

		For State Registrar		ryland / Depa <i>Cel</i>	artment of H			Reg. No.	07	9 8 1	80
Physicia	100	1. Decedent's Name (First, Middle, Last MARGARET H.	SAVAGE				Month MARCH	Day 12,	2007	9:05	
/Medica Examine	_	4a. Facility Name (If not institution, give	street and number)	7	4b. City, Town, or BISHOPV		th	4c. Cou	nty of Death	i	
Funeral Director		222-14-5091	7. Age	(In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h y, Year) 1927	Coun	lace (State or latry) TON, DE	
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND WORCEST.		10c. City, Town or Lo					1	0d. Inside City	
h with the	Funeral Director	10e. Street and Number 13204 WORCESTER	HIGHWAY		10f. Zip Code 21813			-	of What Coun	-	-
urs a	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		Race - Americ Black, White, ecify: BLA	etc.	
nd Z1Z15-003 e filed within 72 hours all Hygiene. other than "natural". vent, the Madical Extr	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo)	orking		f Business/Ind		
	To Be C	17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Na	me (First, Middle, ED DEAN	Maiden Sun	name)		
C = 04 F		19a. Informant's Name/Relationship (T) CLARENCE SAVAGE		1320		STER HWY	., BISH	OPVILL	E, MD	21813	
0 00		20a. Method of Disposition 1			osition (Name of matory or other place CHURCH CE		Date R. 17, 2007		on - City or To		
Baltimo permit. Pag Department Important: It eny injury o once.		21. Signature of Funeral Service Licens	10	1261 W	ATSON FUNITLLSBORO,	IERAL HOI		6			
executed executed an and rial-transit	Ical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Support that y list our diffure, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	uar c	ccid	ent			Approximate Interval Between Onset and De	een aath
The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d.	Date of delive Month	-	ear
igne te t	2	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to			ne cause of de ably 4 ∐Ur	
N VICAL MECOLOS, hystolan: The law requires this certificate has been signed if director, page 2 should be.	e Completed	05.386					1 Tes	rmed? 204No	b. Were auto prior to cor death? 1 \(\subseteq Yes	psy findings available of care	variable use of
ng P fter t	ToB	25. Was case referred to medical examiner? 1 Yes 2 He 27. Manner of D ath 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatien 28a. Date of Injury (Month, Day		f 28c. Injury Work	er: 4 🗌 Nursing I	ath (Check only of Home 5 Residence of 28d. Pescribe h	dence 6 🗆	Other (Specificurred	1)	
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	reet, factory, office		281. Location (S City or Tox		imber or Rura	l Route Numb	er,
the Hospi in 24 hour the Funer pletely fill	Medical	one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	examination and/or in	vestigation, in my of	oinion, death occ	urred at the time,	date and pla	ce, and due to	the cause(s)	
To T with	2	29b. Signature and title of Seniner	/ n	10	29c. License	00394	19	29d. Date sig	ned (Month,	Day, Year)	007
BA3		30. Name and addless of person who co	Dowt	Ne M	Print)	5N.1	Villia	ms:	S+ <	Selb	401
Stat Registra		31. Date filed (Month, Day, Year) MAR 1 4 20	32. Pagistrar	's Signature	poste		* *				1

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ia Bell Stepher	1	State of Maryland I-For State Registrar	d / Department o <i>Certificate o</i>			Mental		201 Reg. No.	07 09081
Physicia ledical Exami	_	1. Decedent's Name (First, Middle, Last) Mia Belle Stephensc	n				2. Date of De Month March 1	Day Year	3. Time of Death 1538 hrs
		4a. Facility Name (if not institution, give street and number Suburban Hospital	er)	4b. City, Te		cation of De		4c. County of D	i
Funeral Director			Age (In yrs. last birthday) 1	If Unde	r 1 Year	If Under 24 Hours		Birth(MM/DD/YYYY) 9	
nd show any ce.		Usual Residence of Decedent 10a. State 10b. County MD Montgomery	10c. City, Town or Loca Potoma						10d Inside City Limits 1 X Yes 2 No
with the Maryland ns 23a or 28a-f show be notified at once,	Director	10e. Street and Number 9724 Pleasant Gate Lane		10f. Zip	Code 20854	1		10g. Citizen of What United Sta	
r death or iter must	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12 Was Decede Armed Force 11 Yes 15 Yes of Dates.	s? If` 2 XX No	Yes, specify Yes 2	Cuban, M	lexican, Pu	(Specify Yes or Nerto Rican, etc.) of work done	14. Race - A White, e Specify: 16b. Kind of Busin	lack
5036 within 72 hours afterene than "natural", Medical Examiner	Completed	15. Decedent's Education (Specify only highest grade of College (1-4 of O	during r	nost of work		O NOT use		N/	
ore, MD 21215-0036 ost and 2 should be filed within 7 ost 1 and 2 should be filed within 7 litem 27 is marked other than 1 filem 27 is marked other than the raumatic event, the Medica	Be	17. Father's Name (First, Middle, Last) Sharif Stephenson	Laon Mari			Amar	nda Clai	, Maiden Surname) CISSA SMI umber, City or Town, S	
MD 2 d 2 shoul Ith and M n 27 is m	٩	19a. Informant's Name/Relationship (Type, Print) Amanda Clarissa Smith (mot	her) 9724	Plea	sant	Gate	Lane, Po	otomac, MD	20854
Baltimore, MD 21215 permir Pages I and 2 should be filed Deparment of Health and Mental Hy Important: If item 27 is marked on injury or other traumatic event, the	1	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from 4 Donation 5 Other Specify:	Chesapeak	ther place) e Cre	mator	cy 3	Date 3/22/2007	-	ille, MD
Physician Physician		21. Signature of Funeral Service Licensee 23. Part I. Enter the disease, or complications that caus	_ 7	400	Georg	gia Av	ve., NW,	Washington	rvice, Inc. n DC 20012
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a co	myelitis						Between Onset and Death
ord."	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		_					
executed an and K	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a co	nsequence of).						
60, nte be executed nysician and	Medical	XUNPENDED #1,3a,PII	,27,28a-f, perM	E , g868,	6/22/	/07 TT		23d Date of de	lives
Box 68760, he death certificate by the attending physical bed for use as the bu	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 9 Unknown 9 Unknowr	at time of death 5 C	etal death Other (Spec	3	Ectopic pre	egnancy	Month	Day Year
ires that the d signed by the		Part II. Other significant conditions contributing to de Remote head injuries		underlying	cause give	en in Part I.			te to the cause of death? Probably 4 Unknown
cords law requ has been 2 should	Completed by						per	opsy price formed? dea	ore autopsy findings available or to completion of cause of ath? Yes 2 No
	BeC	25. Was case referred to medical examiner?	atient 2 🗸 ER/Outpatier			hor	eck only one) ursing Home 5	Residence 6	Other:
n of Vir nding Physic th :: After this e funeral dir	ion: To	27. Manner of Death 1 Natural 5 Pending	injury ly,Year) 28b. Time of		28c. Injury		28d. Describ	e how injury occurred	
Division of Vital I To the Hospital or Attending Physician: whin 24 hours after dealt. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be 4 Homicide Getermined (Specify)	unk f Injury - At home, farm, str house	eet, factory	, office buil	lding, etc.	28f. Location		or Rural Route Number, City Lane Potomac, MD
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physician: To the best of one) 2 Medical Examiner:On the basis of each of the control of the basis of each	examination and/or investig	urred at the	time, date	and place, death occur	and due to the cared at the time, da	ause(s) and manner as te and place, and due	s stated. e to the cause(s)
To with To Con	Mec	29b. Signature and title of certifier	ed.	290	O.C.M			29d. Date signed March 16, 20	(Month, Day, Year)
		30. Name and address of person who completed cause Ana Rubio MD. Assistant Medical Ex		Street. E	Baltimore	e, MD 21	201	<u> </u>	
S	tate		strar's Signature	on the				-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland 1997 arment of Health and Mental Hygiene Confidence of Health and Mental Hygiene Confidence of Health and Mental Hygiene of Hygiene o 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Mildred 845 AM march 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Health Can Montgomera Facility Oachers bure 9. Bithplace (State or Poreign Country) ff Under 1 Year | If Under 24/Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (If yrs last birthday) **Funeral** Hours 1 □ M 2 😡 F 90 Director 478-05-9135 WV Aug 28, 1916 Usual Residence of Decedent with the Maryland Montgomery Montgomery 10a. State 10c. City, Town or Location 10d. Inside City Limits in then "netural", or Iteme 23s or 28s-f show 1 Tes 2 No Gaithersburg Director Upper Marlboro MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue #313 20072 **20877** permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiana. Important: if Item 27 is marked other then "netural", or Iteme 23a with Injury or other treumatic event, the Mudical Examplement once. 14303 Rectory Lane United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: þ 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William F. Murphy Hila Mathews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14303 Rectory Lane Upper Marlboro MD. 20072 Mary H. Snyder (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 13 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Mitchell Cemetery 2007 Lewis County, WV 22. Name and Address of Facility Devol Funeral Home 21. Signature I Juneral Service Leens 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Epier the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician End Stac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, frame of the cause of the cause (Disease or injury Examiner Due to for as a consequence of The law requires that the death certificate be executed anding physicien end use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ 100 Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknowe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Criknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ➤ 10 24a. Was an ormed? 2 Z No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check on y one : After this ce a funeral dire Hospitaf: Other: 4 darsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٢ 1 fnpatient 2 ER/Outpatient 3 DOA 27. Manner of Math 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Alaturat death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

within 24 hours a To the Funerel [

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

Russell Ave Fernhera bartoursburg 31. Date filed (Month, Day, Year) MAR 13 Registrar's Signature 2007

s sor rson who come cause of eath (Item 23a) (Type, Print)

29c. License number

10059423

29d. Date signed (Month, Day, Year) March 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** ELFROZINI TRIMIAK 3 07 0050 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 84 1 □ M 2 TF 15 Istanbul, Turkey Director 578-76-1576 1923 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notified at 1 X Yes 2 ☐ No Director DC Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 2 and liny or other traumatic event, the Medical Examination once. 2515 R St. SE #215 20020 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ∏Yes ≱∏No fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. þ If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Custodian private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Kuglievan Lauretta Criminali ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2515 R St. SE #215 Washington, DC 20020 Otha Trimiar/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/17/2007 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crem. Brentwood, MD Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signatur 3401 Bladensburg Road, Brentwood, MD 20722 (3a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Days Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of Tripury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 🙀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Decubitus ulcer, diabetes, hypertension, dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed chronic pulmonary disease, depression, chronic 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy dysphegia 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Physician /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran been signed by the s should be detached certificate nours after death.

Ineral Director; After the filled in by the funeral To the Hospital within 24 hours a To the Funeral L

Division or Vital Records, P.O. Box 68760.

Certification: To Medical

Hospital: 1 X npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

29c. License number

D0057630

29d. Date signed (Month, Day, Year)

03-10-2007

Registrar

31. Date filed (Month, Day)

29b. Signature and title of certifier

Word

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10301 georgia Ave. No# 209 Silver Spring,MD 20902 Dr. Anuradha Arun 32. Registrar's Signatur

un.M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:00 P March 14, 2007 Ruth Ethel Tracev /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Calvert County Calvert Memorial Hospital Prince Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F Director 217-70-6579 83 Jan. 10, 1924 Canada 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 XYes 2 □ No Director MD Calvert Co. Chesapeake Beach 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a 2995 Tartan Lane 20732 U.S.A. by Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker <u>Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Elesabeth Baillie</u> ဨ Henry Maurice Hodgins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20639 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s if Health an Nancy Watters (Daughter) 3420 Bayside Forest Court, Huntingtown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) March 15. 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2007 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 21. Signature of Fug 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESPIRATORL TNSUFFICIENCY **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner HUPERTENSION ORTAL Signature of the signat Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transi RYPTOYENIC Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical as the attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, SG PTICEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STAPHYLOCOCCUS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 100 2 ER/Outpatient 3 DOA 1 ₩thpatient Certification: To this funeral 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 To the F

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ND- INTERNAT

32. Registrar Signature

CAR.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

WASSEMA DALUE, C

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29c, License number

DOO 649 61

AWERT MEMORIAL HOSPITAL, PRINCE, FREDERICK-

29d. Date signed (Month, Day, Year)

20678

3/15/2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician Month March 12, 2007 7:45 P Gladys Marie Tomlinson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Frederick Calvert County Calvert County Nursing Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗓 F 82 Director 578-20-1932 Jan. 6. 1925 Maryland Usual Residence of Deceden 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County irel", or Items 23a or 28e-f show Exp. diter invel be notified at 1 ☐ Yes 2 No Director MD Calvert County Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9070 Marcellas Drive 20736 <u>U.S.A.</u> Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: White 3 Widowed 4 ☐ Divorced "neturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) or other treumatic event, the Madical 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "r any injury or other treumatic event, If a M-A gince. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Grace Ellen Smith Thomas Morris Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith E. Langley (Daughter) 9070 Marcellas Drive, Owings, Maryland 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 17. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2007 Brentwood, Maryland 21. Signature of Funeral 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Michael W. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician TYOCARD IN FARETION 112 MINUTED /Medical Due to (or as a consequence of) Examiner DISFAS ARTERI CORUNAR-1 YFAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DULMONARY 1 ☐ Yes 2 ☐ No 3 AProbably 4 ☐ Unknown CHRONIC UBSTRUCTIVE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ALZHEIMFRI 24a. Was an DISPASE autopsy MELLITY 2 No DIABFIRT 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) Certification: 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26358 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICE MJ. 20678 WEIGH MD -31. Date filed (Month, Day, Year) 32. Registra Signature State MAR 1 5 2007 Registrar

			1 - For Stata Registrar	State of M	aryland / [rtment tificate			ınd M		giene Reg. No.2	007	09886
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	Funeral Director		5. Social Security Number 6. Social Security Number 578-66-9283	M 2∭ F 7. AG	ge (In yrs. last bii 87	Yrs.		Days	Hours	Min.	8. Date of Birt 01-12-	rý20	Guat	emala
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	and 2 sho Balth and h n 27 ie ma	·	19a. Informant's Name/Relationship (1 Mayra Miralles/n		_ I	lyat	tsvil	le,	nd Numbe nue Mary	land	20782		Town, State, Zip	
Baltimore,			20a. Method of Disposition → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	()	20b. Place of comete Fami	Ly C	emete:	rer place ry		03-2	2-2007	Guat G	emala Cuatemal	ity, a
Bal	permit. Pe Depertmer important eny injury		21. Signature of Funeral Service Licen Wanda C, V 23a. Part1. Enter the disease, or com	Bacon, C	1.036	/ 3	447 1	4th	Stree	et, 1	N.W. Wa	shing		me, Inc. C. 20010 Approximate
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Division	Pospital or Attend 24 hours after death Punerel Director: stely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of In	ijury - At home, f tc. (Specify)	arm, stre	eet, factory,	office			28f. Location (; City or To		Number or Rur	al Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying The Certifii The Certif	niner: On the basis of and manner s	of examination as	e Jeath nd/or inv	vestigation,	it the tim in my op	e data an inion, dea	d place th occur	and due to the red at the time,	causa(s) a date and p	olace, and due t	o the cause(s)
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K	2(4)		30. Name and address of person who	CMD completed cause of 1 HAM	death (Item 23a)	(Туре,		7600			Avenue Marylan	od 2	ク _ノ ノ 0912	2,2007
	Sta Regist		31. Date filed (Month, Day, Year) NAR 1 4 2007	32. Regist	rar's Signatur	de		Lanu	10	LK	y Lai	.u	UJ14	

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any Injury or of once.		21. Signature of Funeral Service		1	22	2. Name and Addre	ess of Facility p	ope Fune	ral Hom	es. P.	Α.		
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for use as	N	IF FEMALE; 23b. Was decedent pregnant		utcome pf pregnan		∃Ectopic pregnanc	, ,		23d. I	Date of deliv	ery		
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should	Completed										, , , _		
01	ple							24a. Wa	s an 24 opsy	 b. Were auto prior to co 	opsy findings availa impletion of cause		
oage	ПО							per	formed? 2 X No	death? 1 ☐ Yes			
tor, F	BeC	25. Was case referred to medica	al				26. Place of	Death (Check only					
director, page	.0	examiner? 1 [X Yes 2□ No	Hospital: 1 🔀	Inpatient 2□E	R/Outpatier	nt 3□ DOA Oti	ner: 4 🗆 Nursir	ng Home 5□Re	sidence 6 □0	Other (Speci	fy)		
funeral	-	27. Manner of Death	28a. Date	e of Injury	28b. Time o				e how injury occ		1.		
ff.	tion	1 □ Natural 5 □ Pendi 2 ☑ Accident invest	ng igation M	onth, Day Year)	1 · Injury		rk?]Yes 2. ⊠ No	Motor	Vehicl	e. A	carlent		
y the	fica	3 Suicide 6 Could	not be 28e. Place	ce of injury - At hor		reet, factory, office		28f. Location	(Street and Nu	mber or Rur	al Route Number,		
i b	Certification:	4 ☐ Homicide determ		ding, etc. (Specify)		March.	1001.0	City or T	own, State)	1.1c	Marila		
ll ed		200 Cartifiar 18 Cartis	ng Physician: To th	c 4 and	ledge deat	h occurred a the	ime, date and n	place and due to #	e cause(s) and	ANJO	stated.		
tely f	ica	(Check only 2 Medica	I Examiner: On the	basis of examinati	on and/or in	ivestigation, in my	opinion, death	occurred at the tim	e, date and plac	e, and due	to the cause(s)		
completely filled in by the funeral	Medical	one)		nner stated.		29c. Licen	ea numbor		20d Det= =1-	nod /Mass	Day Vanel		
00	2	29b. Signature and title of certifi	M	· D		1			29d. Date sig				
		1 41 190				17	344		315	12007			
		30. Name and address of person	n who completed car	use of death (Item	23a) (Type,	Print)					5-6635		
0)		Kent Steven	s. ZZ 5	. Greene	- St.	BAL	- marz	MD	て170	. (

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 12,2007 1050M ElWOOD InoMAS DOUGLAS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Talbot Memorial Hospital at Laston Faston 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1₫M 2□F MD 218-20-768 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No MD CAROLINE DENTON 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21629 USA LUCKAHOE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No BIACK. Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Publishing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SADIE PARENCE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918/ TUCKAHOE Rd DENTON, ML - WIFE 1homas JACQUELINE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐Removal from State DENTON, SPRING GrovE 22. Name and Address of Facility 4 Donation 5 Doth (Specify) 21. Signature of In Price License 1000 N. Dupont Parkwa New Costle DE 19720 MULLTO Spicer-Mullikin Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FERITONITIS Due to (or as a consequence of): BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surresquence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 donknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manger of Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ō

or items

permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner.

Baltimore,

Director

Funeral

Completed by

Be

၉

death with the Maryland

and use as the burial-trai been signed by the attending physician should be detached for use as the burial

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

funeral director,

certificate

this

After

Director

within 24 hours a

To the Funeral Hospital

filled in by

completely

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

1 Matural

2 Accident

3 ☐ Suicide

4 Homicide

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be determined

29c. License number

29d. Date signed (Month, Day, Year) 107

State

Registrar

31. Date filed (Month, Day, Year) MAR 1 5

29b. Signature and title of certifier

ST 2. Registrar's Signature

EASTON, MD 2160

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Elva Elizabeth Timmons 10 2007 11:03 AM March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🔀 F 219-05-5150 Director 92 11 12 1914 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 12 Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Hall Dr. USA 21804 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No þ Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: White "natural", Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Executive Secretery Garment Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f ပ Mary Elizabeth Williams Vollie Hudson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Myrna Lehner (daughter) 303 Hall Dr., Salisbury, MD 21804 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery 03/13/2007 Berlin, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FSPIRATORY FAILURE. HYPOXEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) iner as the burial-transi Exami and Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death Į, in the past 12 months? Day 5 Other (specify) P.O. I signed by the a d be detached fi Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other Sursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 Inpatient 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date sigged (Month, Day, Year) 29b. Signature and title of certifier 0063 12/07 30. Name an 1 addres of person who completed cause of death (Item 23a) (Type, Print) BAI 614 Easternshore Dr Yogesh Vohra M.D. Salisbury MD 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 Registrar MAR 1 3

07-02090 Boston Dean Taylor

Please Type or Print in Black Indelible State of Maryland / Department of				7 0989
- For State Certificate C	of Death	Reg N		1 9505
1. Decedent's Name (First, Middle,Last)		Date of Death Month Da March 17, 20	y Year 07	3. Time of Death 0929 hrs
Boston Dean Taylor 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death)

		1- For State Registrar	- · · · · · · · · · · · · · · · · · · ·	Cen	tificate of	Death		Reg	∠ U ∪ g No	1 0000
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last)			_		Date of Death Month	Day Year	3. Time of Death 0929 hrs
Mulcai Exami	rier	Boston Dean Tay 4a. Facility Name (if not institution, give	street and number)		41	City Town or	Location of Dea	March 17, 2	4c. County of Dea	
		Saint Mary's Hospital	officer and frames,			Leonardtow			St. Mary's	
Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. la	st birthday)	If Under 1 Yea		_	(MM/DD/YYYY) 9. 8	
Director		217-77-4837 ¹ X	M 2 F 2	montl	15 Yrs.	Months Day	s Hours M	Jan. 10	6, 2007 Fore	ountry)Maryland
any		10a. State 10b. County		10c. City,	Town or Locatio	1				10d. Inside City Limits
and f show	5	Maryland St. Man	y's		Mechai	nicsvil]	.e			1 Yes 2 X No
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 40170 Mary Driv	re			10f. Zip Code	20659	10	g. Citizen of What Co USA	untry?
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces?	v			panic Origin? (, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame White, etc.	erican Indian, 8lack,
ifter d		3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year	A No	1 1	′es 2X No	specify:		Specify Whi	te
ours a	d by	15. Decedent's Education (Specify on	ly highest grade con	ipleted)			ion (Give kind o DO NOT use re		16b. Kind of Business	s/Industry
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) N/A	College (1-4 or	5+)	N/A	st of working ine	DO NOT use to	stilled)	N/A	
15-0C filed wit Hygien d other		17. Father's Name (First, Middle, Last)	1					ne (First, Middle, M	,	
2121 uld be t Mental marke	o Be	James Patrick Ta 19a. Informant's Name/Relationship (Ty			19b Mailing	Address (Stree	Andrea	D. Brady	per, City or Town, Sta	te Zin Code)
LD 2 2 shou 1 and b 27 is martic	۲	James P. Taylor,							Le, MD 206	
		20a. Method of Disposition		20b. P	lace of Dispositi	on (Name of ce	metery,	Date	20c. Location - City of	or Town, State
mor Pages ent of ut: If		1 Name Name Paragraph Reference Cremation 3 Other Specify:	Removal from Sta	ate Tri	rematory or othe nity Me	morial	Gardens	March 23, 200	Waldor	f, MD
Baltimore, permit Pages I an Department of Hea Important: If iten injury or other tra	1	21 Signature of Funeral Service Licens	see 1		22. Na	me and Address	of Facility B		l-Echols F	.H., P.A.,
W 8'9'E		four Odet	K				e Notch	Rd., Cha	arlotte Ha	11, MD 20622
Physician //Medical		23a. Part I. Enter the disease, or complete failure. List only one cause on ea	ch line.				such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Examiner			Sudden infa			ne			-	Death
		Sequentially list conditions, b.	740 to (01 45 4 00115t	squeries or,	,					
	iner		Due to (or as a conse	equence of):					
	Examiner	(Disease or injury that initiated	Due to (or as a conse	equence of):					-
kecuted n and transit		d.								
760, cate be ex. physician he burial .	/Medical	XUNPENDED	#7. perFH	, 23a,	27, perME,	g867, 5/2	2/07 TT			
68760, certificate buding physic		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregn	ancy 2 Feta	Ideath 3	Ectopic preg	nancy	23d. Date of delive Month	ry Day Year
Sox 687 leath certific e attending for use as t	icia	past 12 months?	4 Pregnant at	time of dea	ath =	er (Specify)				
. Box he death c y the atten	Physician	1 Yes 2 No 9 Unknown Part II. Other significant conditions	9 Unknown	a but not ro	culting in the un	darlyina cause	iven in Part I	23e Did tob	pacco use contribute t	o the cause of death?
P,O. B es that the digned by the	Ď	Tarrii. Galer significant conditions	contributing to death	Touthorte	sutting in the un	derrying dauge (given in a diet.	1 Yes		obably 4 🗸 Unknown
ords, F v requires s been sign should be	Completed				-,,			24a. Was a		autopsy findings available
e law 1 e has t	ם	-			·			autops	ned? death?	
of Vital Records, ng Physician: The law requir Mier this certificate has been s meral director, page 2 should t		25. Was case referred to medical				26.Place	of Death (Chec	1 Yes 2	No 1 🗸	res 2 No
Vita hysicia this cel	o Be	examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatie	ent 2 🗸	ER/Outpatient	3 DOA	Other Nurs	sing Home 5 F	Residence 6 Oth	er:
1 of Jing Ph	Ë.	27. Manner of Death	28a. Date of Inju (Month, Day,)		28b. Time of Inj		ry at Work?	28d. Describe h	ow injury occurred	
Sion Attenda r death. ector: by the f	atio	2 Accident Pending Investigation					Yes 2 No			
Division ospital or Attendir hours after death.	Certification:	3 Suicide 6 Could not l	pe	ijury - At ho	me, farm, street	, factory, office I	ouilding, etc.	28f. Location (Si or Town, St		Rural Route Number, City
<u>ie</u> 8 5 1		29a. Certifier	()	v knowloda	e death occurr	ed at the time d	ate and place of	nd due to the cause	e(s) and manner as sta	ated.
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner	On the basis of exa	mination ar	nd/or investigation	n, in my opinior	, death occurred	at the time, date a	and place, and due to	the cause(s)
To To	Me	29b. Signature and title of certifier	and manner stated			29c Licens	se number		29d. Date signed (M.	lonth, Day, Year)
		higher, M	dir			O.C.	M.E.		March 18, 2007	
		30. Name and address of person who				D-William	MD 04004		<u>-</u>	
		Ling Li, MD Assistant M	edical Examine	1 111	renn Street	, paitimore,	NID 21201			

State 31. Date filed (Month, Day, Year)
Registrar NAD 2. 7

ORIGINAL

32. Registrar's Signature

MAR 2 7 2007

DHMH 17 Rev 1/2001 OCME 2006

Registrar
DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Marylan		artmen rtificat					giene Reg. No.	0 9 7	0989	
	Physici /Medic									2. Date of Death Month Day Yes 3 7 07					
	Examir		4a. Facility Name (If not institution, given HOLY CROSS HOS		ər)		SILV	ER S	Location (3		4c. County of Death MONTGOMERY			
	Funeral Director		578-56-7945	Gex 7. 1□M 2√F		last birthday) 64 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Bir (Month, Da EB. 28	th iy, Year) , 194		Birthplace (State or For Country) SHINGTON,	
	a Maryland a-f show lifted at	ctor	Usual Residence of Decedent 10a. State 10b. County MD MONTGOM	ERY		y, Town or Lo							-	10d. Inside City Lin 1 XYes 2 ☐	
	3a or 28	al Dire	10e. Street and Number 11425 MAPLE VIEW	DR.			10f. Zip	Code 902			·	_	en of What ED ST		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment in notified at ance.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married					dent of Hi cify Cuba No	spanic Or n, Mexicar Specify:		ify Yes or No can, etc.)	l l	14. Race - American Indian, Black, White, etc. Specify: BLACK		
21215-0036	within 72 ho iene. than "natur he Medical I	Completed	(Specify only highest grade completed) (Giv.					dent's Usual Occupation kind of work done during most of working DO NOT use retired) SINGER					16b. Kind of Business/Industry ENTERTAINMENT		
Maryland 2	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last GEORGE BURKE						18. Mothe	er's Name (LA BEI		, Maiden S	Sumame)		
	nd 2 sho aith and 27 Is mu		19a. Informant's Name/Relationship RONALD ELLISTON/				-				CLVER	-		e, <i>Zip C</i> ode) • 20902	
Baltimore,	Pages 1 a ent of Hea nt: If item ry or othe		20a. Method of Disposition 1 □ Burial ※□ Cremation 3 [1 □ Donation 5 □ Other (Speci		te	Place of Disponentery, crer	natory or c	ther place		Da 3/13/0			ation - City	or Town, State E, MD	
Balti	permit. Departm Importe any inju		21. Signatule of Funeral Service Lice		ller		2. Name ar				MARY			2000 WASH., DC	
	Physician /Medical Examiner		23a. Part1. Enter the diseas / gr con shock, or heart failure. Lift only Immediate Cause (Final disease or condition resulting in death)	PULMONA a	RY FI	BROSIS	er the mod	le of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Batweer Onset and Death	
8760,	sate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	CHRONIC	as a consequence OBSES	SSIVE	PULMO	NARY	DISE	EASE					
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 19-months? 1 □ Yes 2'□ No 9 □ Unknown		B □Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Year					
	w requires that been signed k should be det	þ	a are in, other significant continuous commodified to dealir but not resulting in the shadilying cause given in rearri-							l. 	23e. Did tobacco use contribute to the cause of dea 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Un				
Il Records,	The law reale has be page 2 sho	Completed									24a. Was auto perfo 1 Yes		24b. Were prior death		
of Vital	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	atient 2 🗆	ER/Outpatier	nt 3 🗆 DC	Othe	ar.		Check only o		□Other (S	ipecify)	
Division of	ding After fune	Certification; T	27. Manner of Death X□Natural 5 □ Pending 2 □ Accident investigatic 3 □ Suicide 6 □ Could not t	28b. Time of Injury	f 28c. Injury at 28d. Desc Work? M 1 \(\text{Yes} \) 2 \(\text{No} \)			d. Describe	☐ Residence 6 ☐ Other (Specify) escribe how injury occurred cation (Street and Number or Rural Route Number,						
<u>></u>	itel or Attendurs after deathurs after deathurs all Director;		4 Homicide determined	building,	etc. (Specif)	y) 			*************		City or To	wn, State)		157-1	
	To the Hospitel or Attenswithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical		hysician: To the be miner: On the basis and manner	s of examina		vestigation	, in my op	oinion, dea			date and	place, and o	due to the cause(s)	
	To t withi	M	29b. Signature and title of certifier	M)			D633					signed (Mo	onth, Day, Year)	
2	(15)		30. Name and address of person who IRINA RUBAN, M.D.			1 23a) (Type, GLEN 1	Print)			SPRIMO	, Md.		10-14		
	Sta	ate	31. Date filed (Month, Day, Year)		strar's Signa			0 4.11	- 111 1	> 1 1/11/C	9 114 6		10 17	·	

State of Maryland / Department of Health and Mental Hygiene / [09893 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Paul Wexler March 8, 2007 12:45 P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner John's Hopkins Hospital Baltimore Birthplace (State or Foreign Country)
 NY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
April 21,1935 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Director 100-30-6987 71 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle the Medical Examiner must be notified at 1X Yes 2 No Directo New York Queens Forest Hills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 238 111-20 73rd Ave. Apt. 6-H U.S.A. Completed by Funeral 11375 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Specify: White Maryland 21215-0036 ö 1 ☐ Yes 2K No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural' 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ent: if item 27 is marked other than ury or other traumatic event, its Mis. Elementary/Secondary (0-12) College (1-4or 5+) Private Electrical Engineer 5+17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Wexler Pauline Bragg 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Syed/Cousin 10216 Windsor View Dr., Potomac, MD 20854 permit. Pages 1 and Department of Health Importent: if item 27 any injury or other tr once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cem. 3/14/07 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Ft. Lincoln F. H. 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Parkinon's Disease 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medicai as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year ō Month Day 4 Pregnant at time of death 5 Other (specify) the a o 9 Unknown 9 \ Unknown signed by the of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy After this certificate 1 Yes Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide or la within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel th e 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and D37975 03-15-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Indrisono, M.D. 6410 Rockledge Dr., Suite 401, Bethesda, MD 32. Registrar's Signaliye 31. Date filed (Month, Day, Year) State 5 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2007 MARCH 07, 7:05P MATTHEW WEST HOWARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 F Yrs. Director 02-12-1949 MARYLAND 213**-**46-5490 58 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at MD PRINCE GEORGE CLINTON 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 9211 STUART LANE U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: BLACK ģ 3 ☐ Widowed 4 ☑ Divorced the Medical E Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CHEF PRIVATE 10th other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOWARD JESSIE WEST AGNES ESTELLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 316 CARMODY HILLS SEAT PLEASANT, MD 20743 AGNES HAMILTON/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State HARMONY CEMETERY 03-16-2007 4 Donation 5 Dother (Specify) LANDOVER, MD 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTHERUSCUEROTIC CARDIOVASCULAR DISEASE **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐ Yes 2☐ No detached 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by DIABETES MELLITUS, HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed? certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 Inpatient P 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier ATTENDING PHYSICIAN D52900 03-08-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8700 CENTRAL AV. #301 . LANDOVER MD 20785 MUSA MOMOH MD 32. Registrar's Sign agre 31. Date filed (Month, Day Y State Registrar

			For State Registrer	State of I	Marylan			nt of Hea te of De		Mental Hy	giene Reg. No	2007	09895	
	3.		Decedent's Name (First, Middle,	Last)						2. Date of D Month	eath		3. Time of Death	
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0	(2)		30. Name and address of person wh	no completed cause o	f death (Item	23a) (Type	Print)	カイフとエエ	•		٦.	-13-200/		
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	yland		10a. State 10b. County		10c. City, Tov	vn or Location						10d. Inside	City Limits	
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	vith th	Funeral Director	10e. Street and Number	10f.	Zip Code			10g.	10g. Citizen of What Country?					
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2	8		30. Name and address of person who co											
1			SONIKA PANDEY, M.			ING ST	EET N	W, WA	SHINGTON	DC 2	0422/688			
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Division or Vital Records, P.O. Box 68760 or Attending after death

Director:
d in by the n 24 hours the Funeral Dire Hospital 2

> 10 State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature and title of

Stephen Cafferty HG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Trueman Rd. Lusby mD 20657

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2015 3 10 2007 DONNA MAE WILKERSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Momies Salisbury Peninsula Regional If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Director 1/30/1945 220-42-1442 District of Columbia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f shordical Examiner must be notified at 1 ☐ Yes 2 X No Director VA Accomack New Church 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23415 USA 6060 Holland Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: white ģ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Dorothy Ludwig George Jack Woods 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6834 Shockley Road, Snow Hill, MD 21863 Jason Welch (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3/16/2007 | Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) First Baptist Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 Can 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** wna /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No 2 4 No 1□ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3 DOA 2 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/11/07 H-50493 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21801 Salisby NO Chris Snyder 100 E Carroll St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 1 5 2007

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Williams march 12:30PM ichard 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Veterans Affairs Hospital Baltimore Balhmora If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 12/7/1956 Birthplace (State or Foreign Country)
 Mississippi 5. Social Security Number 7. Age (In yrs. last birthday)
50 Yrs. **Funeral** 220-66-5726 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show r than "natural", or Items 23a or 28a-f show the Wedleal Examinative to collided at Perryville Cecil 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21903 152 Mill Creek Rd. USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Armed Forces.

NEWYes 2 No 1979.

If Yes, Give 1983 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 4 Office Manager Landscape 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hugh Williams Alice Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hugh Williams Father 922 Autumn Valley Lane Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 3/10/2007 Baltimore, MD Metro Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service 12 Ridgely Ave Annapolis, MD 21401 Part1. Enter the disease, of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part1, Enter the disease. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Vascular Physician rebro /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attanding Physician: The law requires that the death certificate be executed as the burial-transit been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: use 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 90 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Tract 24b. Were autopsy findings available prior to completion of cause of death? pi demia, 24a. Was an certificate has autopsy performed? Mitus 1 Tyes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 1 Inpatient P 2 ER/Outpatrent 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D63242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene ST 3D122 SHAH Baltimore Mc 21201 10 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 200 Registrar

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registra Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 13, 12:15 a^M Cynthia Owens Williams 2007 March /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil Perryville 9C Owens Landing Court If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2√2 F 56 Yrs. 218-52-4479 Oct. 26,1951 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count 28a-f show 1 ¥ Yes 2 □ No Perryville Directo Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ the Medical Examiner must be U.S.A. 21903 9C Owens Landing Court Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 0 1 ☐ Yes 2 ☑ No Specify: Specify: ģ White Maryland 21215-003 3 Widowed 4 Divorced "netural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Maryland Transportation other than Elementary/Secondary (0-12) College (1-4or 5+) Authority, Hatem Toll Bridge Two Years Administrative Assistant Perryville, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) d 2 should be fi h and Mental H ' ie marked oth Be Elizabeth Winifred Kincaid Hanford Watson Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Depertment of Health ar
Important: If Item 27 ie
eny injury or other treu 9C Owens Landing Court, Perryville, Maryland 21903 David A. Williams (Husband) Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State West Chester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. 03/17/07 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Immediate Cause (Final disease or condition resulting in death) ancre Physician ances manth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): ettending physicien Box 68760 Physician/Medical the IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 4 Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To SIL funeral 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 11 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No efter death Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral E completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (ttem 23a) (Type, Print) 10 MD ovia DIMONSO. 31. Date filed (Month, 32. Registrar's Signature State Glown & Spark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month. **Physician** 8:18 A M NEAL March 2007 DONOVAN WANG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner La Plata, MD Chartes ivista Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
SEPT. 24, 1941 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1**X**M 2□F 65 MINNISOTA Director 477-42-6017 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 □ Yes XXNo Director MARYLAND CHARLES WALDORF 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ò pe 2204 PINEFIELD ROAD 20601 U.S.A. orant: If Item 27 Is marked other than "natural", or Items 23a injury or other traumatic event, the Medical Examiner must Funera 12. Was Decedent Ever in U.S. Armed Forces? XXVes 2 □ No If Yes, Give Year or Dates: 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: WHITE ģ 3 Widowed XXDivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. GOVERNMENT Elementary/Secondary (0-12) College (1-4or 5+) PROCUREMENT SPECIALIST NSWC INDIAN HEAD s 1 and 2 should be filed wi if Health and Mental Hygier Item 27 Is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM B. WANG MARTHA MELTING ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD20910 19a. Informant's Name/Relationship (Type. Print) SHANNON WANG-DAUGHTER 1401 BLAIR MILL RD., APT#1608, SILVER SPRING permit. Pages 1 an Department of Heat Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) METROPOLITIAN CREMATORY 3-19-07 ALEXANDRIA, VA 2. Name and Address of Facility 21. Signature of Funeral Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NASON /Medical Due to (or as a consequence of) Examiner DURNIED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit law requires that the death certificate be executed rome OBSTRUCTEVE Due to (or as a consequence of) physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cate has been siç , page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 🔲 Inpatient ို this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Aatural To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tire certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Mo

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

altimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division or Vital

			foAmend Item 26 State RegistrarWCHD/SH 3/15	State of Maryla /07 per Dr		artment of H rtificate of L			giene Reg. No.	7 09903
	Physici /Medi		1. Decedent's Name (First, Middle, Last) David Lee Whittin	ngton, Sr.				2. Date of Dea Month March	1 ² 4 20	3. Time of Death 2:31 A M
	Examír		4a. Facility Name (If not institution, give single 22209 Jefferson E			4b. City, Town, or Smiths		Death	4c. County of Wash	Death ington
	Funeral Director		5. Social Security Number 6. Sex 214-48-4292	7. Age (In ye	s. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hours	Hrs. 8. Date of Bird (Month, Da 08/13/1	h y, Year) 1948	Birthplace (State or Foreign Country)
	aryland show		Usual Residence of Decedent 10a. State 10b. County MD Washingto		City, Town or Lo Smith					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	i or 28e-f	Directo	10e. Street and Number 22209 Jefferson E			10f. Zip Code 21783			10g. Citizen of Wha	at Country?
920	be filed within 72 hours after death with the Maryland nat Hygiene. Id other then "natural", or liems 23a or 28e-f show event, the Mudical Examinar ribat be notified at	Be Completed by Funeral Director		2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	U.S. 13.		spanic Origin n, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
Maryland 21215-0036	within 72 ho ene. then "natura the Medical I	mpleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)		16a. Dece (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired) Truck Dr	luring most o	f working	16b. Kind of Busin	ness/Industry
land 5	should be filed within nd Mental Hygiene. marked other then imatic event, the Market heads.	To Be Co	17. Father's Name (First, Middle, Last) Charles Ellsworth	n Whittingto	n		18. Mother's	Name (First, Middle, y Jean Dix	Maiden Sumame)	2.02.0
	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If Item 27 Ie marked eny Injury or other treumatic e Quee.		19a. Informant's Name/Relationship (Type Dennis C. Whittir		r 19b. Maili 222	ng Address (Street a 09 Jeffer	nd Number o	or Rural Route Number.vd., Smith	or, City or Town, Stansburg, M	nte, Zip Code) D 21783
Baltimore,	Pages 1 a ent of Hei nt: If Item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, cre-	osition (Name of matory or other place	· 1	Date 3/14/2007	20c. Location - Cit	
Balti	permit. Depertm Imports eny Inju		21. Signature of Funeral Service License		2:	2. Name and Address	s of Facility		. Minnich	Funeral Home
8760,	physician and physician and physician burial-transit	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a cons	equence of):		, such as ca	8	iesi,	Approximate Interval Between Onset and Death
P.O. Box 6	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Dectopic pregnancy Other (specify)			23d. Date o Month	,
	law requires thet the de es been signed by the a . 2 should be detached f	ρ	Part II. Other significant conditions cont	tributing to death but not r	esulting in the u	nderlying cause give	n in Part I.			ute to the cause of death?
al Records,	: The law requir cete hes been si . page 2 should i	Completed						24a. Was autop perfor 1 Yes	rmieµd? dea	re autopsy findings available or to completion of cause of th? Yes 2 \(\subseteq \) No
Division of Vital	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filed in by the funeral director, page 2	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Accident investigation	ospital: 1 □ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	f 28c. Injury Work	4 🗌 Nursi		V	brothers
Divis	al or Atte s after dea al Directo	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At building, etc. (Spe	home, farm, sti cify)	eet, factory, office		28f. Location (S City or Ton	Street and Number on, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical ((Check only 2 Medical Examinate)	er: On the bast of my k er: On the basis of exami and manner stated.	nowledge, deat nation and/or in	vestigation, in my op	inion, death	occurred at the time, o	date and place, and	I due to the cause(s)
	viti To	-	29b. Signature and title of certifier	bune	-	29c. License	146	473	29d. Date signed (M	14/07
\\d	4-8		30. Name and address of person who con	mdm	am.	j 1130	OPA	LCT	Holger	stown, MS
300 m	Sta Registr	-	31. Date filed (Mon Par Year) 200	7 Secretary Sig	H. A	0.00		,	V	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 9, JAMES WESLEY WEEMS MARCH 2007 9:28 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 XM 2 ☐ F 91 212-16-4847 SEPT. 9, 1915 Director MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and it frem 27 is marked other than "natural", or Items 23a or 28a-f show ant; If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director MD. PRINCE GEORGES COLLEGE PARK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5006 PIERCE AVE. 20740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TX Yes 2 □ No If Yes, Give WWII Year or Dates: WWII 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOV'T PRINTING OFFICE PRINTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 MORRIS WEEMS MARY **JOHNSON** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE W. LIGON/DAUGHTER 5006 PIERCE AVE., COLLEGE PARK, MD. 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department of Important: If it any Injury or o MARYLAND NAT'L. CEM. 3-14-2007 LAUREL, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A MM. Chambrus MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LYOSOL crofic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a genseatience of Physician/Medical Examiner requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has i autopsy performe Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural s after death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

AGMINA

31. Date filed (Month, Day, Year) MAR 13

MO

AHMED IMD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

831

29d. Date signed (Month, Day, Year)

D0060100 . 03-09-7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 18, Aubrey S. Yates March 2007 8:14A 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year)
April 16,1931 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months Days 1 X M 2 □ F Mď. 214-26-7541 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Upper Marlboro PG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20774 United States 9106 Lincoln Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Government Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daniel Yates Agnes Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10304 Duke of Wellington Upper Marlboro, Md. 20772 Court Bruce Yates/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Md. 3/23/07 Cheltenham, Md. Veterans Cem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Sign Jury of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Onset and Death Due to (or as a consequence of):

Physician /Medical **Examiner** Physician/Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Md.

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

requires that the death certificate be executed the burial-transi and as use been signed by the s To the Hospital or Attending Physician: ieral Director: After this of filled in by the funeral direction

Completed by

Medical Certification: To Be

TERRY

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of c. Due to (or as a consequence of d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pre 5 ☐ Other (spe			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying ca	use given in Part I.	23e. Did to	bacco use contribute to the cause of death?
LUNG CAM	ILER			1 □ Y	es 2 No 3 Probably 4 Munknown
				24a. Was a autops perform	prior to completion of cause of death?
25. Was case referred to medical			26. Place of Deat	h Check onl or	ne
examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	oatient 3 DO	Other: 4 Nursing Ho	ome 5 Resid	ence 6 □Other (Specify)
27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Ti		3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, fam building, etc. (Specify)	n, street, factory	office	28f. Location (S City or Town	treet and Number or Rural Route Number, n, State)
29a. Certifier 1 ☐ Certifying Pt (Check only one) 2 ☐ Medical Exam	nysician: To the best of my knowledge, miner: On the basis of examination and and manner stated.	death occurred a l/or investigation,	at the time, date and place, in my opinion, death occur	and due to the or rred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)
29b. Signature and title of certification		29c	License number	2	29d. Date signed (Month, Day, Year)
250. OG 110 CIE		I	40324		MARCH 19, 2007

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a To the Funeral L completely

ROAD, CLINTON, MARULAND

20731

7503 SURRATTS

ddress of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

JOORLE, MD

MAR 2 8 2007

Levi Yates State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 19, 2007 0539 hrs Medical Examiner Levi Yates 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Anne Arunde! Medical Center Annapolis 8. Date of 8irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Pennsylvania If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Director Sept. 18,1999 7 196-78-3122 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits any. 10c. City. Town or Location Prince Georges Bowie Yes 2 No Maryland 28a-f show ified at once Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 20716 USA 16405 Governor Bridge Rd., #102 , or items 23a or must be notif Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, 8 lack If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 Never Married 2 Married 2 X No Yes White Yes 2 No specify: within 72 hours after Divorced If Yes, Give Year Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygene Important: If iten 27 is marked other than "na highry or other transmatic event, the Medical Exp. College (1-4 or 5+) Elementary/Secondary (0-12) N/A Disabled . Father's Name (First, Middle, Last)
Robert Geer, Jr. 18.Mother's Name (First, Middle, Maiden Surname) Jessica L. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23110 Leonardtown, MD 20650 Susan Johnson/Social Worker 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery March 21 crematory or other place 2 X Cremation 3 Removal from State Charlotte Hall, MD 2007 Brinsfield-Echols Crem. Donation 5 Other Specify 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and failure. List only one cause on each line Medical Death Complications of head injury Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical X UNPENDED ned by the attending physician a detached for use as the burial -AMENDED, 27,28a-f, perME, g866, 4/6/07 TI The law requires that the death certificate be Box 68760 23d. Date of delivery 23b. Was decedent pregnant in the Year Live birth Fetal death Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed by ector, page 2 should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, P. pleted should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? . death? page 2 Comi 1 🗸 Yes ✓ Yes 2 No 26 Place of Death (Check only one To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 Yes 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 1 Yes 2 X No 5 Pending Mar. 19, 2000 unk subject assaulted as infant the Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 23335 Maypole Rd. Leonardtown, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide residence determined 4 X Homicide Leonardtown 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier March 20, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #5, 20a Ct 22a Per Fin Penartment of Health and Mental Hygiene 2 0 0

amie Anderson		Amend #5, State of Maryland #1 1. For State Registrar	rtment of tificate of	Health Death	and	Menta	al Hyg	iene R	deg. No.	U	0990
Physicia	an/	Decedent's Name (First, Middle,Last)						Date of Dea Month	oth Day Yea	,	3. Time of Death
Madical Exami	ner	Jamie Anderson 4a. Facility Name (if not institution, give street and number)		b. City, Town	orlo	eation of I		March 19	, 2007 4c. County o	f Death	1607 hrs
		2324 Reisterstown Road	"	Baltimore		cation or i	Death		4c. County c	Death	
Funeral		5. Social Security Number 11711 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1	Year	If Under 2	24Hrs. 8	B. Date of Bir	rth(MM/DD/YYYY		
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		Usual Residence of Decedent		<u> </u>			⁻		1570		
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21215 ould be file Mental Hy marked o	Be	James Anderson					Bre	nda D	ietrich		
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Baltimore, permit. Pages I at Department of Her Important: If ite		1 XX Burial 2 Cremation 3 Removal from State	rematory or oth	er place)							
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Baltimore permit Pages 1 Department of H Important: If i		21 Si mature of Eur ral Service Licensee nald S. wade Director	∽ Ra	ltimor	1000 G	MD -	2120	1 212	21	TE	attret
Physician	1	23a. art I. Enter the dise se, if compile tions that caused the death. hitre List only one cause on each line.								irt	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Narcotic (methad	one) into	oxicatio	on						Death
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	-F	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)):							-	
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Scuted transit	Exa	events resulting in death) Last Due to (or as a consequence of) d.):								
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'60, cate be	Med	IF FEMALE: 23c. If yes, outcome of pregn		, gooo,	4/2/	/U/ 11 -			23d. Date of	delivery	
Sox 6876 leath certificate e attending phy for use as the b	ian/	23b. Was decedent pregnant in the past 12 months?	th -	al death	3	Ectopic p	regnancy	1	Month	D	ay Year
Box 6876 e death certificat the attending phy	Physician/M	1 Yes 2 No 9 V Unknown 9 Unknown	5 Oth	er (Specify)							
O. B. at the de d by the trached f		Part II. Other significant conditions contributing to death but not re-	sulting in the u	nderlying cau	use give	en in Part	I.	23e. Did te	obacco use contri	bute to t	he cause of death?
ision of Vital Records, P.O. Box 6876(Attending Physician: The law requires that the death certificate or death ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the b	d by	Cocaine use						1 Ye	s 2 🗸 No 3	Prob	ably 4 Unknown
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should t	Completed							24a. Was autor	psy p	rior to co	opsy findings available ompletion of cause of
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tal Rectinn: The certificate ector, page	BeC	25. Was case referred to medical examiner?		26.P		Death (C					
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Division tal or Attendi rs after death	icati	2 Accident Investigation Find 3/19/200/ I.	Fnd 3:45 me, farm, stree	Dill 1				unk f. Location (Street and Number	er or Rur	al Route Number, City
Division Hospital or Attened by hours after death Funeral Director: tely filled in by the	Certification	Suicide 6 X Could not be	residence			O.	12	or Town, 3		Rd	Baltimore, MD
Di the Hospital hin 24 hours a the Funeral I reletely filled	- 1	29a. Certifier 1 Certifying Physician: To the best of my knowledg	e, death occurr	ed at the time	e, date	and place	e, and du	e to the cau	se(s) and manner	as state	d.
To the Howithin 24 Particle Functions	Medical	one) 2 Medical Examiner: On the basis of examination an and manner states	nd/or investigati	on, in my opi	inion, d	leath occu	rred at th	ne time, date	and place, and d	ue to the	e cause(s)
FSF5	ž	29b Signature and title of/certifier		29c. Lic					29d. Date signe		th, Day, Year)
7 /		XXVX V		0	.C.M.	.E.			March 20, 2	/ ۱۰۰۷	
7		Name and address of person who om leted cause of death (Item: Susan Hogan MD. Assistant Medical Examiner		n Street, E	Saltim	nore Mi	D 2120	11			
		Susan Hogan MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signatur	re la	7 47 97	Jailli		ا ک ا ک ل	-			
St	ate	31. Date filed (Month, Day, Year)	20 B.	che s							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March Year 40 M **Physician** Samue1 Dennis Brocato 2007 23 /Medical 4a. Facility Name (If not institution, give street and number)

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Battimbre Washington Nedical Current

7. Age (In vrs. last birthday) If Unc 4c. County of Death **Examiner** Anne Amunde 8. Date of Birth (Month, Day, May 21, **Funeral X**XM 2□ F Maryland May 212-10-6848 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10h County r 28a-f show notified at 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or United States 21061 6D Street N.W. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 哲Yes 2 □ No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1943-1 Never Married Married 1 ☐ Yes 📆 No Specify: 1946 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event the Man College (1-4or 5+) Elementary/Secondary (0-12) Utilities Company Electrial Engineer 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Raith Frances Anthony Brocato 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen Burnie, Md 21061 6D Street N.W. Frances Brocato / Wife altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mar. 29, 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven mem. Pk. 2007 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Libenses 22. Name and Address of Facility Kirkley-Ruddick Funeral Home P.A. MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) strok 2 weeks **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and 4 burial-transit that the death certificate be executed Due to (or as a consequence of): physiclan a P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>م</u> 1 Tyes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? 1 Yes 2 No this certificate has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Director: After I or Attending Fafter death. (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral Completely filled in 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 March Clen وه ا، در 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Drive Burnie Medica

Registrar

DHMH 17 Rev 1/2001

State

Baltimore

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year Physician 2:55 pm Lois Irma Burgess MARCH 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ST. AGNES HOSPITAL n/a If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 02/18/1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 👿 F Yrs. 216-12-9764 85 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show of Health and Mental Hygiene. f item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Maryland Baltimore Arbutus Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1317 Maple Avenue 21227 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Burns Louise ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marshall Burgess / Husband 1317 Maple Avenue, Arbutus, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: if its any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 3/28/2007 Elkridge, Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21 Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Encephalopathy Anoxic **Physician** Days. /Medical Due to (or as a consequence of ardiopulmonary arrest 3 Days Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical (F FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 34RGESS Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mnpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this nours after death. Ineral Director: After this y filled in by the funeral di 27. Manne of Death 1 ☑ Natural 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 06062 252

Registrar
DHMH 17 Rev 1/2001

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State

Caton Avenue Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

32. Registrar's Signature

Rbeusing

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Year Nancy Lee Burk March 2007 /Medical 26 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore St. Agnes ltospital N/A Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/20/1937 **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 ■ M 2 🔀 F 216-32-5859 Director 69 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylan 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or Items 23a or 44 Melvin Avenue 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White Completed by 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon A. BUrk, Sr. ပ Marie B. Carle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 North Rolling Road, Catonsville, Maryland 21228 Mr. John Corbitt (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Bayview Crematory 03/27/2007 4 Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature o Fune al Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** encephal pathy Anoxic disease or condition resulting in death) 2 Week /Medical Due to (or as a consequence of): Examiner 2 weeks Scosis Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending p IF FFMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 23d. Date of delivery 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by certificate has been signector, page 2 should f 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number

Registrar

31. Date filed (Month, Day, Year)

, MD

P18617

29d. Date signed (Month, Day, Year) March

RAGAI

900 Cuton Avonue metimone MD 21 32. Registrar's Signature MAR 2 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Mai	-		tificate of		u Mentai n	ygiei Reg. N	200	7 09911
	Dhueisi		Decedent's Name (First, Middle, Last)			-			2. Date of D	eath	ay Year	3. Time of Death
	Physicia /Medic	_	•	LEXANDER	BYRD				March	26	2007	1:15 p ^M
	Examin	er	4a. Facility Name (If not institution, give s				4b. City, Town, o		eath	4	lc. County of Dea	th
	Eupaval		2532 McCULLOH STR 5. Social Security Number 6. Sex		(In yrs. last bir	thday)	BALTIM If Under 1 Year	If Under 24 h	Irs. 8. Date of E	lirth	N/A 9. Bij	thplace (State or Foreign
ļ,	Funeral Director			XM 2□F	67	Yrs.	Months Days	Hours N	Min. (Month, I	29 <u>1</u>		ENNSYLVANIA
	yland yow at		10a. State 10b. County		10c. City, Towr	or Lo	cation					10d. Inside City Limits
	e Mar a-f st	ctor	MARYLAND N/A			BAL	TIMORE					1XXYes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. 0	Citizen of What C	ountry?
	s 23a		2532 McCULLOH ST		an in II C	140 1		217	Casife Vacar		.S.A.	arican Indian
·^	ges 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married Married	2. Was Decedent Ev Armed Forces? 1XXYes 2 □ No					? (Specify Yes or I uerto Rican, etc.)	NO-	Black, Whi	
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lan	should be I and Mental I s marked o	To B	WM ALEXANDER BYRD					BET	TY ANDER	SON		
lar)	2 sho and f is ma		19a. Informant's Name/Relationship (Type	oe. Print)	19b	. Mailin	g Address (Street	and Number o	r Rural Route Nun	ber, City	y or Town, State,	Zip Code)
<u>≥</u> ∂	1 and 2 Health tem 27		Elizabeth F. Byrd/ 20a. Method of Disposition	Wife					Baltimo:	_	Maryland Location - City of	
100	Pages nent of hant of hant. If ite		XXBurial 2 ☐ Cremation 3 ☐ R	emoval from State			sition (Name of natory or other pla	!				
Baltimore, Maryland	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		4 Donation 5 Dother (Specify) 21. Signature of Funday Specify ice		GARRI	22	FOREST Name and Addre	ss of Facility	-03-07			LS, MARYLAND
m	permit. Departm Importa any Inju			pour		W 1	ILLIAM C 206 W NOI	BROWN RTH AVE	COMMUNIT NUE	Y FU	NERAL HO	ME P.A.
П			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused t e cause on each line	he death. Do r	not ent			diac or respiratory	arrest,		Approximate Interval Between Onset and Death
Sec.	Physician		Immediate Cause (Final disease or condition resulting in death)	Carci	noma	1	Bludd	h				2 years
	/Medical Examiner		Tooling in double,	Due to (or as a	consequence	of):						
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	nd A	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
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68760,	tificate g physi as the	edical	d							-	1	
			230. vvas decedent pregnant	3c. If yes, outcome p 1☐Live birth 2		3.5	Ectopic pregnanc	,			23d. Date of de	
Division or Vital Records, P.O. Box	the deat the attr	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at ti 9∏Unknown			Other (specify)	,			Month	Day Year
ٽِ ت	s that ned by e deta	by Ph	Part II. Other significant conditions cor	tributing to death but	not resulting in	n the u	iderlying cause giv	ren in Part I.	23e. Di	tobacc	o use contribute	to the cause of death?
ğ	equire en sig ould b	ed b	Chronic	ributing to death but Coday 15/02	1)150	use	2		_ 1[Yes	2 ∑ No 3□F	robably 4 Unknown
ည် က	e faw r has be	Completed	Hyperte	n 410N					24a. Wa	topsy	prior to	utopsy findings available completion of cause of
a E	n: The icate l								1□ Yes	1157	? death? No 1 ☐ Ye	s 2 No
Ξ	sicial sicertification) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2	lospital:	t 2 ER/Ou	ıtnatier	t 3D DOA Oth	or.	Death (Check onling Home 5		6 □Othor (Co	onife)
יסר	g Phy ter this neral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day	28b.	Time of	28c. Inju Woi	ry at			jury occurred	эспу)
Sion	endin ath. or: Aff	atio	1 Natural 5 Pending investigation				M 1	Yes 2 □ No				
<u>X</u>	after de Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.	y - At home, fa (Specify)	ırm, str	eet, factory, office		28f. Location City or 7	(Street own, St	and Number or F ate)	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.	Medical C	29a. Certifier (Check only one)	sician: To the best of ner: On the basis of and manner state	examination an							
	To the within To the Somple	Me	29b. Signature and title of certifier)			29c. Licens	se number			Date signed (Mor	
			· And		MO			3/52		1	wit 27	
	441		30. Name and address of person who co		38 60	(Type,	Print)	ed #	35 B	alto	, ms a	LIZUS
Г	Sta Registr		31. Date filed (Month, Day, Year) MAR 2. 9 2007	32 Registrar	's Signature	So	uk s					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 11:45 PM BURNS CARL MARCH 22 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) Dec. 14, 1932 MAry Land If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1**☑** M 2□ F 74 216-28-2205 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Middle River MD Baltimore 1 ☐Yes 2 ☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Oak Grove Drive 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗆 No 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Union 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Burns Sr. Amelia White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Burns/son 435 Applegate Court Linthicum MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 3/26/07 Baltimore MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 300 MAce Ave.Balto. Md 21. Signature of Funeral Service Licens Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or conshock, or heart failure List only plications that caused the death one cause on each line. onot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK DAYS disease or condition resulting in death) Due to (or as a consequence of): DAYS ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury TREATON AND THE BY MEDICAL ENGINEER DAYS THIRD DEGREE BURNS that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 3 13 67 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 🗌 Natural 5 Pending investigation tell accurred radicater
28t. Location (Steet and Number or Rural Route Number,
3-13 (Dek Groue Dr., Ratta) 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Examiner requires that the death certificate be executed burial-transit and Division or Vital Records, P.O. Box 68760, physician the t SB attending ed by the a signed to peen certificate Physician: this To the Hospital or Attending

within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

Physician

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ns 23a or 28a-f show must be notified at

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29a. Certifier

s 1 and 2 should be filled within 72 hours after death with the Maryland Health and Mental Hygiene.

Department of Health and Mr. If them 27 1... any injury or c."

Physician

/Medical

3altimore, Maryland 21215-0036

Medical

(Check only one) 29b. Signature and title of certifier Metaus Mathioudel

M.D.

HOME

29c. License number

RES-000

Baltamon 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

MARCH 22, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NESTORAS MATHIOUDAKIS EASTERN AVENUE BALTIMORE, MD M.D 4940 21224 31. Date filed (Month, Day, Year)

State Registrar

			State of Marylan State of Marylan		artment of H			giene Reg. No.20	07	09913
	Physicia		1. Decedent's Name (First, Middle, Last) Julia Buga				2. Date of Dea Month March	Day	Year 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	3. Time of Death 5:02 A M
No.	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County		1
10/40		٠.	4115 Loch Carrow Road			ingham		Bal	etimo.	re
-	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 89	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct. 25	, Year)	Cour	place (State or Foreign ntry) GÍNÍA
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Lo	cation				1	10d. Inside City Limits
	Many fed a	ţo	Maryland Baltimore	No.	ttingham					1 □Yes 2 No
	h the or 28a s noti	irec	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a c	ral	4115 Loch Carrow Road			21236			S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2🂢 No	lispanic Origin? (Span, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Rad Blad Specif	ce - Americ ck, White,	
9	2 hour atural cal Ex	ted t	15. Decedent's Education	16a. Deced	dent's Usual Occup	ation		16b. Kind of B		
215	thin 7% e. an "n Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done DO NOT use retired	during most of wor d)	king			
2	led wi lygier her th	S	12	Hom	emaker	18. Mother's Nam	ne /First Middle		Home	
Maryland 21215-0036	d be fi ental F ked otl	To Be	17. Father's Name (First, Middle, Last) Charles Sabo			Vera	Varga		ne)	
ary	shoul and Me s mark	ř	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street				State, Zip	Code)
	and 2 saith s n 27 is		Julia Ireland (daughter)		5 Loch Ca					21236
ore	jes 1 t of He if Item or oth		IMBurial 2 Ucremation 3 Hemoval from State 1		sition (Name of matory or other plac	1	Date	20c. Location	-	
Ē	tment tant:		4 □Donation 5 □ Other (Specify) 0 a		Cemetery					Maryland
Baltimore,	permil Depar Impor any ir once.). - -	21. Signature of Funeral Service Licensee	9	2. Name and Addre	r Road,	Baltimor	e, MD	2123	
8760,	Physician /Medical Examiner /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if only leading to limit and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consected to the conditions) of the conditions of the condit	Juence of):	an. borllate vdery heart	n. duead				Approximate Interval Between Onset and Death
P.O. Box 68	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	### Pregnant in the past 12 months? 1 ☐ Yes 2 ☐ You 9 ☐ Unknown #### Unknown ##################################	al death 3[Ectopic pregnancy	_V		100	te of deliven	ery Day Year
	s that pred by e deta	by Pr	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to t	he cause of death?
ğ	equire sen sig ould b	ted k	idpory roldum.				1 🗆 Y	es 2 No	3 ☐ Prob	bably 4 Unknown
Division or Vital Records,	yslcian: The law r is certificate has be director, page 2 sh	Completed	•				24a. Was a autop perfor 1 Yes	rmed?	Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of 2 No
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ō	Phys r this eral dii	<u>۲</u>	27. Manne of Death 28a. Date of Injury	ER/Outpatier 28b. Time o	1. 0 DOX	4 Li Nuising n	ome 5X Resid			fy)
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Divis	il or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Special	ome, farm, str	reet, factory, office		28f. Location (S City or Tow	Street and Numb n, State)	ber or Run	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and manner stated.							
)	To the within 2 To the complete	Me	29b. Signature and title of certifier		29c. Licens	e number 0551 7 1		29d. Date signe	ed (Month,	Day, Year)
	P		30. Name and address of person who completed cause of death (Iter School from Thin 3023 (East)	n 23a) (Type,	Print)	Baltimo	ve ma	212	24	
	Sta Registr		Schoston July 3023 East 31. Date filed (Month, Day, Year) MAR 2 9 2007 MAR 2 9 2007	ature she	de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Month March 7:50 A **Physician** 22 2007 Clarence LeRoy Burger, Ir. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours 1 M 2 □ F 60 April 12, 1946 Maryland 218-44-5915 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2 No Perry Hall Maryland Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21128 9509 Kingscroft Terrace, Unit N Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 Mamed Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foam Manufacturing Co. Account Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Steinert Arling Burger, Sr. Clarence LeRou 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128 19a. Informant's Name/Relationship (Type. Print) 9509 Kingscroft Terrace, Unit N, Perry Hall, MD Angelina Burger (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/27/2007 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Europa Service Lin 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final wecks gangrene disease or condition resulting in death) ue to (or as a consequence of) vascular direase oheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (of as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) attending | for use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No certificate 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPIG 3□ DOA 2 ER/Outpatient 1 Yes 2 No Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death
1 Natural
2 Accident (Month, Day Year) After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Director permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 271s marked other than "natural", or Item any Injury or other traumatic event, the Medical Experiment Baltimore, Maryland 21215-0036 **Physician** /Medical **Examiner** The law requires that the death certificate be executed Box 68760. Division or Vital Records, P.O. Hospital or Attending Physician: To the Hospital within 24 hours a To the Funeral I 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number and title of certifier 29b. Signature March 22 200 D58503 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST PONSON MO AMONJ 15 (VV) CHANCES, Registrar's Signature State 2007 Registrar

07-02149 Karla Browne Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Kalla Blowlle		irtment of Health and Mental Hy tificate of Death	giene 200	7 0991
Physician Medical Examine			2. Date of Death Month Day Year March 19, 2007	3. Time of Death 2148 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	ath
Funeral	University Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. la	Baltimore ast birthday) If Under 1 Year If Under 24Hrs.	N / 2 8. Date of Birth(MM/DD/YYYY) 9. B	_
Director	220-76-2079 1 M 2XF 46	Months Days Hours Min.	06/04/1960 Fore	eign ountry/ARYLAND
ow any	10a. State 10b. County 10c. City,	Town or Location BALTIMORE CITY		10d. Inside City Limits 1 X Yes 2 No
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Flygiene. Tanti: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. To Be Commileted by Eumeral Director	10e. Street and Number	10f. Zip Code 21218	10g. Citizen of What Co	44.
with the ms 23a o		S. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No- 14. Race - Ame	erican Indian, Black,
s after death with rran", or items 22 niner must be no by Funeral		If Yes, specify Cuban, Mexican, Puerto R		LACK
2 hours a "natura LExami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire		b/industry DEPT. OF
5-0036 led within 72 hour tygiene. other than "matu the Medical Exan	12TH 2 YEARS	CASE MANAGER	SOCIAL S	ERVICES
21215-0036 hould be filed within 72 hours at a Mental Hygiene, is marked other than "natural utic event, the Medical Examin To Be Committed by	FRANCIOS BROWNE, SR.	MARY	First, Middle, Maiden Surname) E . SMITH	
MD 21 and 2 should alth and Mer m 27 is man aumatic ev	19a. Informant's Name/Relationship (Type, Print) MONISESIE MATHIS/DAUGHTER	19b. Mailing Address (Street and Number or Ru 4501 PARKWOOD AVE	ral Route Number, City or Town, Stat , BALTIMORE, M	te, Zip Code) ID 21206
Baltimore, MD 21215-003 permit Pages I and 2 should be filed withi Department of Health and Mental Hygiene Important: If item 27 is marked other ti injury or other traumatic event, the Med	1 Burial 2 X Cremation 3 Removal from State	rematory or other place)	Date 20c. Location - City of CATONSVI	
Baltimore, permit Pages I an Department of Hee Important: If ite	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	22. Name and Address of Facility	WELL FUNERAL H	OME 21207
Physician	23a (Part I whiter the disease, or complications that caused the death u.g. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or n	TGHTS AVE, BAL espiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Acquired Immune Deficiency Sy	ndrome (ALUS)	Death
1	Sequentially list conditions, if any, leading to immediate b):		-
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
e execute cian and rial - tran	d. X UNPENDED AMENDED AMENDED AMENDED AMENDED 23c, 17, perME, g			
760, icate be physical the bun	IF FEMALE: 23c. If yes, outcome of pregnation the 23c. If yes, outcome of pregnation the 23c. If yes pitch	nancy	23d. Date of delive	
). Box 687 the death certific by the attending p ched for use as t Physician/	past 12 months? 1 Ves 2 No 9 V Unknown 1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 Ectopic pregnant ath 5 Other (Specify)	Cy Month	Day Year
P.O. B s that the d		sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	o the cause of death?
rds, I requires been sig hould be			24a. Was an 24b. Were a	autopsy findings available completion of cause of
Division of Vital Records, P.O. rate or attending Physician: The law requires that the safter death at Director. After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P.			performed? death?	
tal ician: certif rector,	25. Was case referred to medical examiner?	26 Place of Death (Check on ER/Outpatient 3 DOA Other Nursing	·	
of Vi	1 Yes 2 No		Home 5 Residence 6 Other Resid	er:
ion creath tor: Af	1 X Natural 5 Pending (Month, Day,Year) 2 Accident Investigation	1 Yes 2 No		
Division (spital or Attendiny nours after death neral Director: At filled in by the fun Certification	3 Suicide 6 Could not be determined (Specify)	me, farm, street, factory, office building, etc.	8f. Location (Street and Number or R or Town, State)	Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex		ge, death occurred at the time, date and place, and dind/or investigation, in my opinion, death occurred at t		
F % F 8	29b. Signature and title of dertified	29c. License number O.C.M.E.	29d. Date signed (M March 20, 2007	
N	30. Name and address of person who completed cause of death (Item Susan Hogan MD. Assistant Medical Examiner			
State	31. Date filed (Month, Day, Year) 32. Registrar's Signatur			
Registra	MAR 2 9 2007			

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 8:00 PM John Godfrey Baker narch 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deat or Location of Death **Examiner** 10 Kasedale If Under 1 Year | If Under 24 Hrs. Social Security Number Age In yrs, last birthday) 8. Date of Birth (Month, Day, June 22 Birthplace (State or Foreign Country) **Funeral** Days Year, Months Hours 1 X M 2 □ F 86 218-01-3461 1920 **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Miclical Examiner must be notified at Maryland 1 □Yes 2 No Directo Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9608 Haven Farm Road, Unit G 21128 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or I if Yes, Give Year or Dates: WW 11 1 ☐ Yes 2 💢 No Specify: White <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Martin Marietta Co. Elementary/Secondary (0-12) College (1-4or 5+) 12 Photographer Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Baker Bernadine Mast Mary Pages 1 and 2 should ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) p rmit. Pages 1 and 2 D-partment of Health a In portant: If item 27 is Betty Baker (wife) 9608 Haven Farm Rd. Unit G, Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 3/29/2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, Maryland 21236 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 TYes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after uccorr. To the Funeral Director: After ormuletely filled in by the funer Certification: (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar

29b. Signature and title of certifier

Name and address

31. Date filed (Month, Day,

Year)

e of death (Item 23a) (Type, Print

29c. License number

Lc # DOO65094

29d. Date signed (Month, Day, Year)

3/26/07

			1_ For State	State of Ma		d / Dep	artme	ent of H		and M		/giene	2007	0017
	Physici	an	1. Decedent's Name (First, Middle, Last) Gay Carroll Bruce				TUIIC	ile Oi	Deali		2. Date of D	Reg. No eath Da	y Year	3. Time of Death
	/Medi Examir		4a. Fecility Name (If not institution, give s	HYTON N			BNITE		r Location	of Death	Bur	ME	7 200 County of Dea AMN	th 2 ARUNDE
	Funeral Director		Usual Residence of Decedent	M 2∑F 7. Age	85	last birthday Yrs.	Month		Hours	Min.	8. Date of Bi (Month, D FEB 26	ay, Year) ,192	22 Lou	thplace (State or Foreign ountry) iisiana
	the Marylar 28a-f show	ector	MD Anne Arus 10e. Street and Number	ndel		y, Town or L thicum	n	Zip Code				10a Ci	tizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 📉 No
	sath with	Funeral Director	551 First St	12. Was Decedent E	uat in H	6 12	21	090		-i-i-2 (C	-4. V N	USA		
9000	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examinar must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 X No. If Yes, Give Year or Dates:		3. 13.	_	edent of Poecify Cuba 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Specify		cify Yes or N Rican, etc.)	0-	Black, White	
21215-0036	within ene. than	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		-)	(Giv	e kind of y DO NDT		ation during mos d)	st of workin	ng		and of Business	
Maryland 2	be filed tal Hyg d othe event,	To Be Co	17. Father's Name (First, Middle, Last) Marshall N. Carrol	1		Store	e_Own	er			(First, Middle	, Maiden	dware S	tore
	d 2 sh h and 7 is m traum		19a. Informant's Name/Relationship (Ty) James Bruce/Son	pe, Print)			-				n, MD 2		or Town, State, .	Zip Code)
Baltimore,	Pages nent of ant: If it		20a. Method of Disposition 1 ☐ Burial 2 【X] Cremation 3 ☐ R		C	lace of Disp emetery, cre ro Cr	ematory o	r other plac	.)		407		ocation - City or Limore,	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License 23a. Part1. Enter the disease, or compli- shock, or heart failure. List entry on	[∞] C. Todd	Drin	g c	22. Name remat 99 Fi	and Addre ion eder	ss of Facili Socie	ety of Ed Bal	Mary]	Land,	Inc.	
	Physician /Medical		23a. Par11. Enter the disease, or complishook, or heart failure. Vist only on Immediate Cause (Final disease or condition resulting in death)	INEL	MI	+1 F+C		ode of dyin	g, such as	s cardiac or	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	Examiner	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	Due to (or as a										
60,	ate be executed hysician and the burial-transit	ai Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequ	uence of);								
89	death certificate e attending phys id for use as the	<u>.</u> 0	IF FEMALE:	3c. If yes, outcome o	f pregna	ncv								
P.O. Box		Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal	death 3	□Ectopic □ Other (pregnancy specify)					23d. Date of del Month	Day Year
Ś	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	tributing to death but	not resu	alting in the u	underlying	cause giv	en in Part I	l.		tobacco i Yes 2		the cause of death?
	The ste h	Completed									24a. Was auto perfe 1 🗆 Yes		prior to death?	Itopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:				Oth	or:		(Check only			
on of	After After fune	ertification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☑Inpatien 28a. Date of Injury (Month, Day		ER/Outpatie 28b. Time o Injury		28c. Injun Wor	/ at	2	e 5 ⊟ Resi 8d. Describe		6 □Other (Spe ry occurred	cify)
Division	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Certific	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At ho (Specify	me, farm, st	reet, facto	ory, office		2	8f. Location (City or To			ural Route Number,
	ths Hospi in 24 hour the Funer pletely fill	edicai	29a. Certifier (Check only one)	ician: To the best of er: On the basis of e and manner state	examinat	vledge, deat ion and/or in	th occurre nvestigation	d at the time on, in my o	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) date and) and manner as d place, and due	stated. to the cause(s)
ŀ	To t To t com	2	29b. Signature and the of dertifier	D	n	nio	2	9c. Licenso	S C	19		29d. Dai	te signed (Mont	h, Day, Year) 27 2007
	10		30. Name and address of person who do	moleted cause of dea	ath (Item	23a) (Type	Print)	1166	9	Cen	Bu	bye	e 201	61
	Sta Registr	.4	31. Date filed (Month, Day, Year)	32. Registrar			B.J		0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25,2007 Month **Physician** 5 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner at the Wicomico isbur á ake Ice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 20, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Months 1 ☐ M 2 💢 F 1949 57 Director 217-52-3879 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f shov dical Examiner πust be notified at 1 ☐ Yes 2 No Director Bishopville MD Worcester Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene.
Insit If Iten 72 Is marked other than "natural", or items 23a or 28aury or other traumatic event, the Medical Examiner must be notif 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12445 Dixie Drive 21813 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk College (1-4or 5+) Elementary/Secondary (0-12) sales administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Samuel Young Winnie Elizabeth Pusey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Baker/spouse 12445 Dixie Drive Bishopville, MD 21813
of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wa 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD Approximate Interval Between Onset and Death Immediate dause (Final Matstat 10 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 10 Jas autopsy perform certificate I 1☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes No funeral director 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending Natural 2 Accident 5 Pending investigation within 24 hours after com...

To the Funeral Director: Aft 1 Yes 2 No Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Year)

MAR 2 9

32. Registrar

		-	For State Registrar	State	of Maryla			of Healt of Dea		fental Hyg	iene	07	09919
	sicia	_	1. Decedent's Name (First, Middle Rita G. Bas							2. Date of Deal Month March 10	Day	Year 7	3. Time of Death 9:15 PM M
	edic imin	_	4a. Facility Name (If not institution 2513 Harlem	, give street and n	number)			own, or Locati			4c. Coun	ty of Death	
Fune Direc			5. Social Security Number 220-48-3856	6. Sex 1 □ M 2 ∏ F	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Months	Year If Un Days Hou	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day, Nov 6,	^{Year)} 1948	Cou	place (State or Foreign intry) Land
e Maryland	THE PARTY	ctor	Usual Residence of Decedent 10a. State 10b. County MD	·	10c.	City, Town or Lo	imore						10d. Inside City Limits 1 Yes 2 □ No
th with th	10000	Funeral Director	10e. Street and Number 2513 Harlem Ave	enue			10f. Zip C		216	1	0g. Citizen o	f What Cou USA	.ntry?
it c, IMAI YIAII.U Z I Z I D-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show	THE REAL PROPERTY.	۵	11. Marital Status 1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed	s 2 ⊠ No Give		Was Decede If Yes, specif	y Cuban, Mex	ican, Puerto	ecity Yes or No- Rican, etc.)	ВІ	ace - Ameri lack, White, cify: b1a	, etc.
within 72 ho ene. then "netur	a water	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12	t grade completed	d) (1-4or 5+)	(Give	DO NOT use	done durina r		ing	16b. Kind of	Business/ir	ndustry
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nd 2 shoul alth and Mari		-	19a. Informant's Name/Relations Jacqueline B.		isterr		-	Street and Nu	mber or Rura	al Route Number ue Minde	City or Tow		
Pages 1 and the state of the st	100		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S			o. Place of Dispo cemetery, cre				Date	20c. Location	n - City or T	own, State
permit. Pages: Depertment of H Important: # Ite	SUCE.		21. Signature of Euneral Service ROPALO	Wade,	Direct			Anatomy ore, Mi		d 655 W. 01	Balt:	imore	Street
Physici /Medi	cal		23a. Part1\Enter the disease/or shock, or heart failure. List Immediate Ca\se (Final disease or condition resulting in death)	only one cause on	each line.	TIC PA					est,		Approximate Interval Between Onset and Death MONTHS
cate be executed EX physicien and who buriel transit		dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s	o (or as a cons								
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy monetain thin the funeral director, need 9 the attendant of the physician by the attendant of the physician of the physician physician of the physician physician of the physician		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live	outcome of preg birth 2 Fignant at time of	etal death 3	Ectopic pred					Date of delive	rery Day Year
quires that the signed by		<u>م</u>	Part II. Other significant condition	ens contributing to	death but not i	resulting in the u	nderlying cau	use given in Pa	art I.	23e. Did tob	~	ntribute to t	the cause of death?
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Physician: The Physician: The Physician: The Physician of the Physician of		0 0	25. Was case referred to medical examiner? 1 Yes 2 No			ER/Outpatier		Other: 4	Nursing Ho	me 5 Reside	ence 6 🗆 O		(by)
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this cardificate the commonant director in the funeral director page.		Certification:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	g (Mo	e of Injury onth, Day Year,	28b. Time o Injury t home, farm, sti	М	c. Injury at Work? 1 Yes 2	No	28d. Describe ho	. ,		al Route Number,
To the Hospital or Attendi Within 24 hours after death. To the Funerel Director: A			4 Homicide determ	g Physician: To the	lding, etc. (Spe	ecify)				City or Towr	n, State)		
o the Hourithin 24 h		Medical		Examiner: On the			vestigation, ii		death occurr	red at the time, d		e, and due t	to the cause(s)
F 5 F (30. Name and address of person	who completed ca	2D	tom 22a) (Type	Print)	7182	787		MAR	20	2007
	Stat	e	AUL GON 31. Date filed (Month, Day, Year)	MEY 32.	900 Registrar's Sig	O CA	TON	AVE	13	SALTIM	ORE	MI	21229
Rec	jistra	r	MAR 2	9 2007	Males of	15. 16	DEREAL						

State of Maryland / Department of Health and Mental Hygiene Amend #1&23b&C Per PHY G865 3/29/07 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Bradley James Day **Physician** 9-10 Au 2 07. D /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner SILVER SARING KI HABBILITATION TONTGONERS 9. Birthplace (State or Foreign Country) Washington DC If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F 6 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If ten 27 is marked other than "netural; or items 28e or 28e-f show eny Injury or other treumatic event. The Medical Examinate 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2601 Bel Pre Road 20906 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 □ X es 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married altimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eleventh Private Shoe Repairman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Bradley Helen Hodge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2202 Marbury Drive, District Heights, MD 20747 Annie L. Bradley/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico National O National 2007 Triangle, Virginia 22. Name and Address of FacilityRobert G. Mason Funeral Home Inc 21. Sign ture of Funeral Service in 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Thave. disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Dementia attending physician and for use as the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 De Wentie Physician/Medical Due to (or as a consequence of) signed by the a d be deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ robably 4 □ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? been sign 24a. Was an autopsy performed? Completed certificate has b irector, page 2 s 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director; Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dooppoog 9 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) owner client Ave #202 Silver Spring dr 2 DDL MD-20906 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

07-02129 Kay Brodie Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

•		I- For State Registrar	or waryland		tificate o		and went	arriygiche	Reg. No.	200	1 0992
Physicia Medical Examin	n/	Decedent's Name (First, Middle,La						2. Date of Do Month	Day	Year	3. Time of Death 0555 hrs
iculcul Examin		Kay F Brown 4a. Facility Name (if not institution, g	odie ive street and number)		4b. City, Tow	n, or Location o	March 1		ounty of Death	
		2311 Glen Allen Avenue				Silver S	pring			ntgomery	
Funeral Director		578-58-2411	Sex 7. Ag		ist birthday) Yr		Year If Under Days Hours	Min.	15 , 19	Foreig	thplace (State or on Washington ^{untry)} DC
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	tion					10d Inside City Limits
A *	۱,	MD Montgome	ery	S-	ilver S	Spring					1 X Yes 2 No
Maryland • 28a-f sho	اف	10e. Street and Number				10f. Zip Co	ode		10g. Citizer	n of What Cou	ntry?
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eath w	Funeral	1 Never Married 2 Marrie	Armed Forces		S. If	Yes, specify C	Suban, Mexican,	Puerto Rican, etc.)	14.	White, etc.	carrindan, black,
after d al", or	표 참	3 Widowed 4 Divorce	or Dates:	A NO	1	Yes 2X	No specify:				lack
hours natur Exam		15. Decedent's Education (Specify	only highest grade cor				cupation (Give k g life. DO NOT i	ind of work done use retired)	16b. Kind	d of Business/	Industry
hin 72 e. than tagical	ompleted	Elementary/Secondary (0-12)	College (1-4 or	3+)	Bank	Telle	r			Banking	
0 2 4 2	탉	17. Father's Name (First, Middle, La	st)		Dann			s Name (First, Middle			
d be fi fental larked	o Be	Lonnie W. Head			10h Maile	- A data /	Th	elmal C	obb.	as Taum Chats	Zin Codo)
MD 2 d 2 shoul lth and M n 27 is m aumatic	-1	19a Informant's Name/Relationship Dashawn L. Brodie			1	,		. Silver		,	20906
re, N 1 and 1 Health Fitem or trau		20a. Method of Disposition			Place of Dispo rematory or o	sition (Name	of cemetery,	Date	20c. Loc	cation - City or	
Pages nent of ant: I		1 XXBurial 2 Cremation 3 4 Donation 5 Other Speci		ate	e of H	eaven	Cem.	March 28,	ol Si	lver S	pring, MD
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental Ity Important: If item 27 is marked o injury or other traumatic event, Ith		21. Signature of Funeral Service Lice	ensee		22.	Name and Ad	dress of Facility	Austin Ro	yster	Funera	al Home
Physician	7	23a. Part I. Epter the disease, or con	nphications that caused	the death.	Do not enter	the mode of d	n Street lying, such as ca	t, NW, Was	ningto arrest, shock,	on , DC , or heart	20011 Approximate Interval
/Medical		failure. List only one cause on	each line. Hypertensi								Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a cons								
	P.	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of	·):						-
	E۱	(Disease of Injury that Initiated	Due to (or as a cons	equence of)-						
cuted nd ransit	<u>ا</u> ۵	events resulting in death) Last	d.	equence or	<i>)</i> -						
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760, ficate be g physic s the buri	§ [IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco		nancy			pregnancy		Date of deliver	y Day Year
Box 687 ne death certific the attending I hed for use as the	cial	past 12 months?	4 Pregnant a	t time of dea		etal death other (S <i>pecify</i>		pregnancy	"``	Jilli I	su, tea
Bo he deal y the al	Physician/	1 Yes 2 V No 9 Unknow Part II. Other significant condition	9 Unknown	h hut not ro	aulting in the	underlying or	uso aivon in Pa	rt 23e Dir	tobacco use	e contribute to	the cause of death?
ries that the signed by	ব	Diabetes mellitus	s contributing to deal	in but not re	sulling in the	underlying ca	use given in Fa				pably 4 Unknown
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Division of Vital Records, ta or Attending Physician: The law requirers after death. al Director: After this certificate has been seled in by the funeral director, page 2 should the selection of the funeral director, page 2 should the funeral director.	힑		<u> </u>				· ·	pe	opsy formed? s 2 No	death?	
of Vital Reco ing Physician: The law After this certificate has uneral director, page 2 s	ادہ	25. Was case referred to medical				26.		(Check only one)			
'Yit'		examiner? 1 Yes 2 No			ER/Outpatier			Nursing Home 5	Residence	e 6 🗸 Othe	r: Scene
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r Atter r Atter er deat rector	icat	2 Accident Investiga	ation 28e Place of I	njury - At ho	ome, farm, stre	eet, factory, of	ffice building, etc			Number or Ru	ural Route Number, City
Div ours aft eral Di	Certification:	3 Suicide 6 Could not determine						or Town	, State)		
8 - = 8	- 1	29a Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of n	ny knowledo	ge, death occu	urred at the tin	ne, date and pla	ice, and due to the ca	ause(s) and r	manner as stat	ed ne cause(s)
To the within To the comp	Medical	29b. Signature and title of certifier	and manner stated	auon a			icense number	and amo, de			onth, Day, Year)
		Date: One	P	DA.	L		D.C.M.E.		March	h 21, 2007	
7	-	30. Name and address of person wh	o completed cause of	death (Item	23a)						
0		Patricia Aronica-Pollak N		_		111 Pen	n Street, Ba	Itimore, MD 212	201		
Sta Registi	_	31. Date filed (Month, Day, Year)		ar's Signatu	y A	arte					

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

			riease i	State of Marylar				-		_	•
			1 - For State Registrar	State of Marylar		ertificate of L			-	2007	09922
			Hegistrar 1. Decedent's Name (First, Middle, Last)	1		ortinoate or L	Catir	2. Date of De	Reg. No ath	.007	3. Time of Death
	Physici		PADNEU 9		CLA	RK		Month	Day	y Yea	10 .04
-	/Medic Examir		4a. Facility Name (If not institution, give		<u> </u>	4b. City, Town, or	Location of Deat			. County of De	
1.			BALTIMORE VA A	1EDICAL CE	NEK	BAL	Moll	_	I	BALTIMO	RE CITY
	Funeral		Social Security Number 6. S			/) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	. (Month, Da	y, Year)	9. 8	irthplace (State or Foreign Country)
	Director		217-40-9347 Usual Residence of Decedent	6	4 Yrs.			SEPT. 2	5, 19	942 MA	RYLAND
	land ow		10a. State 10b. County	10c. C	ity, Town or I	Location					10d. Inside City Limits
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	h the	Director	10e. Street and Number	JADDEL TO	DDIV DO	10f. Zip Code			10g. Cit	izen of What	Country?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Mcdical Examiner must be mailfind at		466 KENILWORTH CT.			21061			UN	TED ST	ATES
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Amed Forces?	J.S. 13	. Was Decedent of His If Yes, specify Cubar	spanic Origin? (9 n, Mexican, Puer	Specify Yes or No to Rican, etc.)		14. Race - An Black, Wi	nerican Indian, nite, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 X Yes 2 □ No 19 If Yes, Give Year or Dates:	863	1 ☐ Yes 2 ☒ No	Specify:			Specify:	TT TOTAL
21215-0036	tural	ed t	15. Decedent's Edu		16a, Dec	edent's Usual Occupa	tion		16b. K	ind of Busines	HITE
15	ihin 72 ho e. an "natu	plet	(Specify only highest grade Elementary/Secondary (0-12)	e completed)	(Giv	re kind of work done d DO NOT use retired)	uring most of wo	rking	100111		
212		Completed	12	College (1-4or 5+)	COMP	UTER TECHN	ICIAN		CC	OMPUTER	RS
g	be filed ntal Hygi ed other event, I	ВеС	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden	Sumame)	
yla	should but marked	To	JOSEPH REDMAN				EVA I.	CLARK			
Maryland	2 sho		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mai	ling Address (Street a.	nd Number or Ri	ural Route Numbe	er, City o	r Town, State	Zip Code)
	s 1 and 2 should if Health and Men item 27 Is marke other traumatic		LaRue Rawlings / C			KENILWORTH		LEN BURN		MD 21 ocation - City of	.061
آو	Pages nent of H int: If ite		1 🕅 B∯rial 2 □ Cremation 3 □ R	emoval from State	cemetery, cri	ematory or other place	1				
Baltimore,	C 42 -3		 4 □ Donation 5 □ Other (Specify) 21. Signature of Functial Service License 			LLE MD VE. 22. Name and Address		2007	CRO	WNSVILI	LE, MARYLAND
Ba	permit. Depart Import any inj		M Worth	X		KIRKLEY-RU 421 CRAIN	DDICK F	UNERAL H	OME BURI	NIE. AME	21061
			23a. Part1. Enter the disease, or compli	cations that caused the dea	th. Do not e						Approximate Interval Between
	Pnysician :	6 17	shock, or heart failure. List only or Immediate Cause (Final disease or condition			CANCER					Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		CANCER					
Н	Examiner		Sequentially list conditions).							
V	sit sit	luei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
4	sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	uence of):						
760,	te be e ysician ne buria	calE									
687	ificate g phys as the										
Вох	death certifica e attending ph ed for use as th	M/U	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		☐Ectopic pregnancy				23d. Date of d	elivery
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of o		Other (specify)				Month	Day Year
P.O.	that the death certifica ed by the attending ph detached for use as th	Physician/Med	9 Unknown		10°			an Bit			1 dank 2
	Se un o	by	Part II. Other significant conditions cor	ithouting to death but not res	sulting in the	underlying cause give	n in Part I.	236. 010 10			to the cause of death? Probably 4 Unknown
o.	w require been si should t	etec									
Rec	has has ge 2 s	Completed						24a. Was autop	an isy rmed?	prior to death?	autopsy findings available completion of cause of
Vital Records,		e Co	25. Was case referred to medical					1 Tes	2 Z No	1 🗆 Ye	s 2 No
Ē	Physiclan: this certific ral director,	To Be	examiner?	ospital: 1 XInpatient 2 -	FR/Outpatie	ent 3 DOA Other	-	ath <i>(Check only o</i>		6 □Other (So	acifu)
J Of	g Phys er this teral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		at	28d. Describe h			ouny)
jor	Attending in death.	atlo	1 Natural 5 Pending 2 Accident investigation	(Morall, Bay Four)	injury		es 2 □ No				
Division	after death after death Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	om <i>e</i> , farm, s	treet, factory, office		28f. Location (S City or Tox			Rural Route Number,
۵	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,			1				<u> </u>			
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or i	ith occurred at the time nvestigation, in my opi	e, date and place nion, death occu	rred at the time,	cause(s) date and	and manner a place, and du	as stated. Le to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and mannor stated.		29c. License	number		29d. Dat	e signed (Mor	nth, Day, Year)
	P ≤ P Ő		100000	111		Pic	1858		Ma	ch	7.6 7007
	01	}	30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type	, Print)	-		- ur	16.1	-4, 200
_			C ZELBE	10 No	THE	GREE.	NEST	REET "	BA	LTIM	26, 2007 OREMDZEO
	Sta		31. Date filed (Month, Day, Year) MAR 2 9 2007	32. Registrar's Signa	ature	A Comment			•		
	Registr	al l	MALO	34	6						

State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death	Re	g. Nö.	1 49923
	Disconinina	1. Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·			2. Date of Deeth Month		3. Time of Death
	Physician /Medical	MARGUERITE I. CAIN		-		MARCH	27 20	1078:30 MM
	Examiner	4e Fecility Neme (If not institution, give street and number)			4b. City, Town, or		4c. County of	f Death
			CEN TO		BACTI		N/A	9 Birthologo (State or Foreign
	Funeral Director	5. Social Security Number 6. Sex 1 M 2 X F 7. Age 1 M 2 X F	(In yrs. last birthde	Months Days	Hours Min.	(Month, Dey,	Yeer) 1910	9. Birthplace (State or Foreign Country) MARYLAND
		Usuel Residence of Decedent	90			ACC JI	1710	PHINTHIND
	how in the state of the state o	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Sa-f.s	MARYLAND N/A		BALTIMO	RE			1⊠ Yes 2□ No
	er death with the Marylan terms 23s or 28s-f show over must be notified at unersi Director	10e. Street and Number		10f. Zip Code		10	ng. Citizen of Wh	nat Country?
	23a	6040 HARFORD ROAD			1214	it. V N-	U.S.A	- American Indian.
	r thems 23	11. Marital Status 12. Was Decedent E- Armed Forces? 1 Never Married 2 Married 1 Yes 2 M N	verin U,S.	Was Decedent of F If Yes, specify Cub.	an, Mexican, Puerl	o Rican, etc.)		, White, etc.
Maryland 21215-0036	in 72 hours after death with the Maryland "natural", or items 23a or 28e-1 show redical Examinet must be notitled at	3 ☑ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:		Specify:	BLACK
9	ed within 72 horygiene. Try then "natural it, the Medical in Completed	15. Decedent's Education	16e. De	cedent's Usual Occup	pation	ting 1	16b. Kind of Bus	iness/Industry
21		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	-) life	ive kind of work done a. DO NOT use retire	d)	All 19		- (=DG
7	other the	12yrs 2yrs	HOUS	SEWIFE/TEA		(F) 1 14 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		E/EDUCATION
and	fental H rked out tic even	17. Father's Neme (First, Middle, Last)				ne (First, Middle, M)
ž	5 4 8 8 F	JOHN BRUNER 19a. Informant's Name/Relationship (Type, Print)	10h 14e	ailing Address (Street		TTE BRUNE		tota Zin Cadal
Ma	nd 2 sho alth and 27 is mu		0.00	Box 165,				
ē,	# P E E	William B. Cain/Son 20a. Method of Disposition	20b. Place of Dis	sposition (Name of				lity or Town, State
Ë	8 5 5 >	1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		rematory or other place. Y CEMETERY	1	04-03-07	DARITNG	TON, MARYLAND
Baltimore,	교 문원들 .	21. Signature of Foreval service Lyan ee						HARFORD, P.A.
m	Depa Impo any li pnce	1 Expure	"					, MD 21001
		23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not					Approximate Interval Between
	Physician	Shock, or heart failure. Elst only one cause on cach line	•					Onset and Death
	/Medical Examiner	Immediate Ceuse (Finel disease or condition	STAGE	DEMER	NTIA			
п		resulting in deatiny	ue to (or es e cons					
W	executed in and ial-transit	b	SES ASSERBITION ALCOHOLOGIC	nistopijininės –				
7	ntificate be executed ing physician and a as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	ua to (or as a cons	saquence of):				
68760,	ficate be physician as the buri	that initiated events	ue to (or as a cons	seguence of).				
99	ng phy a as th	resulting in death) Last	(
Вох		d	 				-	
	he at he at hed for	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23b. Did tob	pacco use cont	ribute to the cause of death?
P. O.	The law requires that tha daath ce atle has been signed by the atlands, paga 2 should be detached for uss.					1 □ Ye	8 2 No 3	3 ☐ Probabty 4 ☐ Unknown
ds,	signe d be					24a. Wes en	autoney	24b. Were autopsy findings
ö	been shoul					perform		aveilable prior to completion of cause
æ	has ga 2					400	s aleno	of death?
<u>a</u>	n: The filicate h or, page	25. Was case referred to medical			26 Place of Dog	1 ☐ Yes		1 Yes 2 No
<u> </u>	hysician: his cartific il director To Be	examiner? 1 ☐ Yes 2 ☐ Mo Hospitel: 1 ☐ Inpatien	t 2 ER/Outpat	ient 3 DOA Oth	or:	lome 5 Resider		(Specify)
0	Attending Physician: r daath. ector: Aftar this cartific by the funeral director, iffication: To Be (27. Menner of Death 1\Delta Matural 5 Pending (Month, Day	28b. Time		y at k?	28d. Describe hor	w injury occurred	d
<u>S</u>	aath. br: Aff he fu	2 Accident investigation			Yes 2 □ No			
Division of Vital Record	tal or Attending Pis after daath. al Director: After tied in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	y - At home, farm, (Specify)	street, factory, office		28f. Location (Str. City or Town,	eet and Number , State)	r or Rural Route Number,
	pital purs a pur	29a. Certifier 117 Sertifying Physician: To the best of	mu knowladgo, do	ath populated at the time	no doto and place	and due to the ee	use(a) and man	nor on stated
	To the Hospital or Attending Physician: The law within 24 buours after dash. To the Funeral Director. Attar this cardificate has completely filled in by the funeral director, paga 2 Medical Certification: To Be Comp	29a. Certifier 11 Contifying Physician: To the best of check only one) 12 Medical Examiner: On the basis of end manner state	xamination end/or	investigation, in my o	pinion, death occu	rred at the time, da	te and place, an	id due to the cause(s)
	Within To the compl	29b. Signeture end title of certifier MGDICAL	77752011	29c. Licens				(Month, Day, Year)
)		1 Modern	10000	7 201	06273	9 1	MARCH	127 2007
	12	30. Neme end address of person who completed cause of dea	ath (Item 23e) (Typ	e, Print)	Man	NAING	06,1	10
	7	GENESIS HAMILTO	on Con	Ton,	BAZT	MO RE		10
	State	31. Dete filed (Month, Day, Year) 82. Registrer	's Signature	,				
	Registrar	MAR 2 9 2007	A. Gos	40)				

DHMH 16 Rev 6/95

ORIGINAL

			State of Maryla	•	rtment of He			2000	1 00021
			Registrar Decedent's Name (First, Middle, Last)	Cel	incate of L	Jean	2. Date of Death		3. Time of Death
	Physici		James Per	cry Ca	arter		Manth :	25 2007	1:58 a M
	/Medio Examir		a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De	
			Joseph Richey Hospice		Balto			NA	
	Funeral		MTM 2□F	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		212-44-7908 65 Isual Residence of Decedent				8 13	1945	N.C.
	yland		Oa. State 10b. County 10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	MD NA Ba	altimo	re				1X Yes 2 □ No
	vith th	Director	Oe. Street and Number 2441 Barclay Street		10f. Zip Code	.218	10	g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at	eral	-	10 12 1	Vas Decedent of His		ofu Voc or No	USA	merican Indian,
10	fter d	Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ No	J.S. 13. V	Yes, specify Cubar	n, Mexican, Puerto I	Rican, etc.)	Black, W	hite, etc.
036	ours a	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give ☐ Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	Black
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occupa kind of work done di	uring most of working	ng 1	6b. Kind of Busine.	ss/industry
121	within ane. Ihan	mp	Elementary/Secondary (0·12) College (1-4or 5+)		OO NDT use retired)		ı	Weber Mo	ovina
d 2	filed Hygie ther t		8th grade NA 7. Father's Name (First, Middle, Last)	Hel		18. Mother's Name			7 4 11 9
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "naturel", or items 23a or 28a-f ehow raumatic event, I'm Mudical Examinat must be notified at	To Be	James Willard Carter			Maggie	Graham		
ary	shou and N		19a. Informant's Name/Relationship (Type, Print)		g Address (Street a				
1	D = 21		Nathaniel Carter-Brother		McCullo				
altimore,	Peges 1 ar nent of Hea nut: If item rry or oths		Typequal 2 Cremation 3 Hemovalinon State	_	sition (Name of natory or other place			0c. Location - City	
≫/4 =	it. Pe rtmen rtant: njury		4 Donation 5 Other (Specify) M1 21. ignature of Funeral Service Licensee	Zion	Cemete Name and Address			Lansdown	ı, MD
) S. Ba	permit. Peges 1 Department of H Important: if ite eny injury or ot		Joseph R. Walt	Unn	1101 E	E. North	Avenu	e Balto	MD 21202
			23a. Pa . Enter the disease, or complications that caused the dea huck, or heart failure. List only one cause on each line.	ith. De not ente	er the mode of dying	, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician		mn ed ate Cause (Final display or condition esulfing in death)	5 54	drame				Onset an∋ Death
	/Medical Examiner		esulfing in death) Due to (or as a conse	quence of):	+				weis
2	Examine:	-	Sequentially list conditions,	quence (f):	emily u	cer			
10	uted J Insit	Examiner	ause. Enter Underlying Cause (Diseese or injury	40000	1				3
18 °	execting the end of the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the end of the ending the end of the ending the end of th	Exa	hat initiated events c	quence of):					
2/876	cate be executed chysicien end the burial-transit	dicai	d						
9	certifica nding pt	Med	F FEMALE:						
Box	death ce e attend ed for us	lan/	23b. Was decedent pregnant in the past 12 months?	al death 3	Ectopic pregnancy			23d. Date of a Month	delivery Day Year
, 3 o	n requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of 9 ☐ Unknown	death 5∟	Other (specify)				
120	that hed by deta		art II. Other significant conditions contributing to death but not re	sulting in the ur	derlying cause give	n in Part I.	23e. Did tob	acco u <i>s</i> e contribute	to the cause of death?
S rds	quires n sigr uld be	ed by	Diabetes				1 ☐ Yes	s 2 No 3	Probably 4 Unknown
ecords,		Completed					24a. Was an	24b. Were	autopsy findings available o completion of cause of
~ ~	sician: The lav certificete has rector, page 2	Com					autopsy perform	ed? death	es 2 No
Vital	clan: ertific ector.	Be C	5. Was case referred to medical examiner?			26. Place of Death		7.00	-1
\$ 5	Physic this c	P	1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2	ER/Outpatient		4 Nursing Hon			oecity) HOSPICE
	ding P. After funera	ion	77. Manner of Death 1	28b. Time of Injury	28c. Injury Work M 1 TY	at ? es 2 □No	8d. Describe hov	w injury occurred	
Division	Attendictor: Aeath	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At I	nome, farm, stre			Bf. Location (Stre	eet and Number or	Rural Route Number,
į	s after s Dire	Certification:	4 Homicide determined building, etc. (Spec	ify)			City or Town,	State)	
	To the Mospital or Attending Physician: The la within 24 hours after death. To the Funers! Director: After this certificete has completely filled in by the funeral director, page 2	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr Check only one) 1 Certifying Physician: To the best of my kr Check only one)	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the car d at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the vithin To the comple	Me	9b. Signature and title of certifier		29c. License	number	29	d. Date signed (Mo	nth, Day, Year)
	7		> 75780 MD		D24	170		March 26	, 2007
1	0		O. Name and address of person who completed cause of death (Ite	m 23a) (Type, I	Print)	Baltin			1
	Sta	te.	11. Date filed (Month, Day, Year) 32 Registrar's Sign	ature /	maw 21	Ballim	ou, pu	1 2120	
	Registr		MAR 2 9 2007	ature for	ne!				

			1 - State Amend #10e&19h	State of Maryland / Per FH G865 3/	Department of F Certificate of I	lealth and Me <i>Death</i>	ntal Hygieno Reg. No	e 2007	09925
	Physici /Medic		Decedent's Name (First, Middle, Last) ANTHA	COATES			Date of Death Month WWW 26		3. Time of Death
	Examir Funeral Director		5. Social Security Number 6. Sex	OSPITAL	RAND	ALLSTO C If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year		MORE place (State or Foreign intry) AND
	Maryland f show ied at	tor	10a. State 10b. County	MORE 10c. City, To	wn or Location RANIO	A115TO1	24)		10d. Inside City Limits 1 □Yes 2 No
36	3a or 28a- st be notif	al Director		hleign	10f. Zip Code	21/33	10g. Ci	itizen of Whet Cou	ntry?
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 22 No	Ispanic Origin? (Specif en, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ameri Black, White,	
21215-0036	within 72 hou ene. than "natura he Medicai E	Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16	a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of working	16b. h	Kind of Business/Ir	idustry
	be filed wit ntal Hygien of other tha event, the	Be	17. Father's Name (First, Middle, Last)		NURSES	18. Mother's Name (F		A	
Maryland	nd 2 should be lth and Mental 27 is marked (27 is marked or traumatic ev	2	19a. Informant's Name/Relationship (Typ	De. Print) 19	b Mailing Address (Street	Heign RD:	AN Route Number, City		RSEV
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Opnation 5 Other (Specify) 21. Ignature of Funeral Service License	emoval from State cemet	of Disposition (Name of ery, crematory or other place) Sol Folia 22. Name and Address	Date Date Sign of Facility 1	4	ocation - City or T	
	RA 트 등 등	-	Part1. Inter the disease, or complice shock for heart failure. List only on runnediate Cause (Final disease or condition	cations that caused the death. Do e cause, on each line.	o not enter the mode of dyin	lg, such as cardiac or r	NAVE. Sespiratory arrest,	BALTO.	MD 2/2/7 Approximate Interval Between Onset and Death
68760,	/Medical Examiner bhysician and sthe burial-transit	edical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence	e of):				
Records, P.O. Box (The law requires that the death certifical te has been signed by the attending phy agge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 ⊟Ectopic pregnancy 5 ⊟ Other (specify)			23d. Date of deliv	very Day Year
	quires that t in signed by uld be detac	by	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause give	en in Part I.			the cause of death?
	2 38	Completed					24a. Was an autopsy performed? 1∐ Yes 2 M No	prior to co	opsy findings available ompletion of cause of 2 ☐ No
z Vii	ding Physician: The	To Be	1 les 2 les 140	ospital: 1 Inpatient		4 LI Nursing Home	5 Residence	6 ☐Other (Speci	fy)
ision	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	27. Manne Death 11 atural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of injury - At home, f		Yes 2□No	I. Describe how inju		al Route Number.
ā	pital or ours after eral Dire filled in t		4 Tiornicide	building, etc. (Specify) Ician: To the best of my knowledge	ne death occurred at the tin	ne date and place and	City or Town, State		etatod
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical	(Check only 2 ☐ Medical Examin	er: On the basis of examination a and manner stated.	ind/or investigation, in my o	pinion, death occurred	at the time, date an	nd place, and due t	to the cause(s)
)	No To	#Z	29b. Signature and title of certifier	М	Hoo S	1339	.A. a	nte signed <i>(Month,</i>	
5	1	-	30. Name and address of person who con	mpleted cause of death (Item 33a) 540 OU CT-Re	· Kandally to	wy MD Z	1133		
	Sta Registr	- 111	31. Date filed (Month, Day, Year) MAR 2 9 2007	32. Registrar's Signature	(park)				

TIMOTHY CONNER 07-02268 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Medical Examiner Timothy H. Conner March 24, 2007 0940 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 26 Country Club Lane **Baltimore County** 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 217-62-0729 Director Months Davs Hours 1 XM 2 F 48 April1,1958 Country) Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 28a-f show MD HArford Joppa Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene anti- (filem 27 is marked other than "matural", or items 23a or 28a-4 shours to ther transmite event, the Medical Examiner must be notified as anneased. 1 Yes 2 X No rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 623 Shore Drive 21085 USA Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married White, etc. Yes 2X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2X No specify. White Specify: ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Building Superintendant Gem Craft Homes 12th 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Be Hugh J. Conner Norma L. Moe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Conner /brother 8588 Manorfield Road Balto. MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith 3/29/07 Rossville Department of Important: MD Denation 5 Other Specify ture of Funeral Service Lice 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line /Medical Between Onset and a Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease of injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED attending physician or use as the burial -AMENDED Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Month Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 ✔ No 3 Probably 4 Unknown Completed Division of Vital Records, s been s 24a. Was an 24b. Were autopsy findings available autopsy has 7 prior to completion of cause of performed? death? certificate h ✓ Yes 2 1 🗸 To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be Other₄ Inpatient 2 this ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other: Scene 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification: within 24 hours after wor.

To the Funeral Director: A' FOUND: Natural Passenger involved in plane crash 5 Pending 1 Yes 2 ✔ No Mar 24, 2007 0930 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide 26 Country Club Lane, Phoenix, MD (Specify) Single Family (yard) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 25, 2007 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2007 Registrar

			State of Maryland / Dep		lental Hygid	ene						
				rtificate of Death		Reg. No. 2007 0002						
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	1 Never Married 2 Married 1 Yes 24 No	1 Yes ¾ No Specify:	,		hite					
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	the hin 24	ed	and mariner stated.		ed at the time, date	and place, and due	to the cause(s)					
	5 ¥ € 6	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)					
	6		M.D.	D56531		MArch 26,	2007					
	12		30. Name and address of person who completed cause of death (Item 23a) (Type,		Mana	01045						
			Harry Li, M.D. 8600 Snowden River 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Pkwy, Columbia,	maryland	21045						
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		For State Registrar			State of	Marylan		artment of rtificate o		nd Mental H	ygien Reg. N	6 U L		099	328
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2 sho		19a. Informant's Na	ame/Relatio	nship (Typ	e. Print)		19b. Mailin	g Address (Stree	et and Number o	or Rural Route Num	ber, City	or Town, St	ate, Zip	Code)	
		Richard	Carmi	chael	/ so	n	3607	Byron	Circle,	Frederic	k, M	arylaı	nd	21704	
i i of es		20a. Method of Disp		. a 🗆 🖪		20b. P	lace of Dispor	sition (Name of natory or other p	lace)	Date	20c. L	ocation - Ci	ty or To	wп, State	
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permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A.													
99789		Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707											,		
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0	Naul G Story D 29923 March 27,							20	07						

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

20707

30. Name and address of person who completed cause of death (pem 23a) (Type, Print)

Marie Dobyns, M.D. 7350 Van Dusen Road, Suite 320, Laurel, Maryland

egistrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** RAYMOND L. CARTER JR. 2007 MARCH 23 8:45A /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALICE MANOR NURSING HOME BALTIMORE CITY N/AIf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 → M 2 □ F 68 03/29/1938 WASHINGTON, DC 578-50-8737 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Examiner must be notified at XXYes 2 No Director N/A MD BALTIMORE CITY 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2095 ROCKROSE AVENUE ō 21211 USA 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status Black, White, etc. US XYes 2 □ No If Yes, Give 1X Never Married 2 Married Saltimore, Maryland 21215-0036 Year or Dates 5 5 - 5 9 1 ☐ Yes 2 🔀 No Specify. Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturally Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) FEDERAL AVIATION Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATION CIVIL SERVICE 10TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RAYMOND L. CARTER, SR. MARY YOUNG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHARON WELCH / SISTER 4709 PELHAM CT., TEMPLE HILLS, MD 20748 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

O VETERANS CEM. 3/29/07 OWINGS MILLS, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Fugeral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, he discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art to irre. List only one cause an each line. Approximate Interval Between Onset and Death Immedia suse (Final disease condition resulting an death) Leumonia Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, leave and a leave and a leave ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Jimo Di Dooze Due to (or as a consequence of) physician s the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28h. Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year)

-IAQ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wren 21, 200 Sandra Cottle 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Greneral altimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☐ M 2 🖸 F 213-34-8271 Sept 16, 1935 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1√2 Yes 2 □ No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2700 N. Charles Street 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify: Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 disabled unk none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Keene/friend 5006 E. Oliver Street Baltimore, MD 21205 Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Specify) in state 21. Signature of Euneral Service Dicensee Ronald 8. Wade, Dikector 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 20a. Part1. Arter the disease, or commodal ns flat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) 1055TWE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an was autopsy performed? 1□ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed burial-tran physician the as use for ed by the a signed by page 2 should certificate has

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed by funeral director, Be ို After this Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After filled in by the

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a or

6

"natural",

r than "natur the Medical

Department of Health and Mental High Important: If item 27 Is marked other any Injury or other traumatic event, the once,

Physician /Medical

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

þ

Completed

Be

9

25. Was case referred to medical 1 ☐ Yes 27. Manper of Death 1 Natural 2 Accident

29a. Certifier

(Check only

5 ☐ Pending investigation

3 ☐ Suicide determined 4 ☐ Homicide

6 Could not be

(Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work? 1 ☐ Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death-filem 23a) (Type

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 29 2007

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 23 Jilliam Month UNCan 5:56 AM 12007 larch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bon Secours Hospital Baltimore 1 Year | If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01 05 9. Birthplace (State or Foreign 1 M 2 □ F Days Hours Yrs. Director 248-72-0713 61 46 SC Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits notified Director MD NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 Funeral 2754 West Mosher Street 21216 U.S.A. 14. Race - American Indian, Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatin event. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give If Yes, Give Year or Dates: 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced Specify: Black 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Mover na Dutton Moving Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William L. Duncan Sr. Hattie Hebb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Duncan-Son 663 Lake Shores Dr., Portsmith, VA 23707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3/30/2007 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying bause, (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Pulmonary Obs Muchyl Completed 1 Yes 2 No 3 Probably 4 Vnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No P 1 Alpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2∏No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

death certificate be executed physician and the burial-transit Box 68760, as attending use jo P.0. the á signed b Records, has page certificate Division or Vital director this After

28a-f shov

death

Baltimore, Maryland 21215-0036

Hospital or Attending ospitan4 hours after dec... -..neral Director: After within 24 hours at To the Funeral D completely the

Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

title of pertifier

29b. Signature and

Name and address of person who completed cause of death (Item 23a) (Type, Print) Strut 22. Registrar's Signature

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated.

29c. License number

Bultimore,

29d. Date signed (Month, Day, Year)

4b. City, Town, or Location of Death . Facility Name (If not institution, give street and number) Examiner Battimor HOSD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Numbeunk 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 78 Oct 19, Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location or iteme 23a or 28a-f show attent Known as Rawmond Diaz St. Mary's Charlotte Hall Direct 10e. Street and Number 10f. Zip Code 20622 29449 Charlotte Hall Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2□No Specify: mexican þ 3 ☐ Widowed 4 ☑ Divorced "natural" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 end 2 should be filled within 7. Depertment of Health and Mental Hyglene. Important: if item 27 is marked other then "ne eny injury or other treumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) Sinai Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☒ Other (Specify) in state 21. Signature of Euroral Service Licensee Ronald S. Wade Baltimore, MD 21201 Immediate Cause (Final disease or condition resulting in death) Myo Cardial
Due to (or as a consequence of): Physician /Medical **Examiner** Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed

Decedent's Name (First, Middle, Last)

Raymond Diaz

Physician

/Medical

Division of Vital Records, P.O. Box 68760

death.

within 24 hours after deat To the Funeral Director;

the Hospital

in by the

18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 W. Belvedere Avenue Baltimore, MD 20c. Location - City or Town, State 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 3 Probably 4 ZUnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available phor to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient Certification: To Yes 2 □ No 3□ DDA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene/

2. Date of Death

March

3. Time of Death

9. Birthplace (State or Foreign Country) unk

10d. Inside City Limits

1 ☐ Yes 2√2 No

unk

2007

4c. County of Death

10g. Citizen of What Country?

Specify

16b. Kind of Business/Industry

Race - American Indian, Black, White, etc.

white

18

825PM

Registrar

				For State Registrar	State of Ma			nt of Healtl <i>te of Dea</i>			iene U eg. No.	JU/	09933
	The state of the s			Decedent's Name (First, Midd	fle, Last)					2. Date of Dear	th	V	3. Time of Death
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4		/Medic Examin		4a. Facility Name (If not institution			4b. City	, Town, or Locati	on of Death		4c. Cou	unty of Death	
-				Good Samaritan Hos				Baltim					
		Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last birth	Months		der 24 Hrs. rs Min.	8. Date of Birth (Month, Day 06/16/19	Year)	9. Birthp Coun	lace (State or Foreign htry) MD
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		and and		10a. State 10b. Count	у	10c. City, Town	or Location					1	Od. Inside City Limits
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	;	r 28a	Director	10e. Street and Number			10f. Z	ip Code		1	0g. Citizen	of What Coun	•
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		- dea	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Dec If Yes, sp	edent of Hispanic ecify Cuban, Mex	Origin? (Spe tican, Puerto I	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
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0	21215-0036	yiene r the	Completed	Elementary/Secondary (0-12)	College (1-4or 5)+)	d	omestic			hou	ısewife	
	p	e file al Hyg othe	BeC	17. Father's Name (First, Middle				18. M	lother's Name	(First, Middle,			
	Val	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene and waturelt, or Itema 23a or 28a-f ehow the marked other then "naturelt, or Itema 23a or 28a-f ehow aumatic event. The Madical Examinat mat be motified at	To I	Robe:	rt Hamilton						n Diggs		
HANNOR	Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Because it is the marked other then "naturely, or thems 23a or 28a-1 ehow eny injury or other traumatic event. The Madical Examinal must be multified at once.	1 3	19a. Informant's Name/Relation Derek Glenn, Sr.		19b.	Mailing Address 2323 N.	ss (Street and Nu Dukeland S	otreet;	<i>I Route Number</i> Baltimore	, City or To	land 212	216
3	ē,	Heal Heal tem 2		20a. Method of Disposition		20b. Place of				ate	20c. Locati	ion - City or To	own, State
5	<u>o</u> E	ages ent of nt: If I		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 □Removal from State (Specify)	1	r, crematory or rorial P	_	03/31	/2007	Randa 1	lstown, l	Maryland
Z	<u>=</u>	mit. Partmoortar		21. Signature of Funeral Service			22. Name	and Address of Fa	acility Wv	lie Funer	al Home	e. P.A.	
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				23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that caused st only one cause on each li	the death. Do no	ot enter tne m	ode of dying, such	n as cardiac o	or respiratory arr	est,		Approximate Interval Between
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		/Medical		resulting in death)	Due to (or as	a consequence o	f):	J.					
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	687	ficate phy: s the	edicai		0.								
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	P.O.	at the by th stache	hys	9 Unknown						1			
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	o to	Phys this al dir	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju			JOA 4L		me 5 Resid			(y)
	ב	ding h. After funei	ē	1-☐Natural 5 ☐ Pend	/Month Co		jury	28c. Injury at Work? 1 ☐ Yes					
	Division of Vital Records,	al or Attendir setter death. I Director: Af d in by the fur	fica	3 Suicide 6 Coul	d not be 28e. Place of Inj	ury - At home, far	m, street, fact	ory, office				lumber or Rura	al Route Number,
	ă	spitel or Attending Physicien: ours efter death. heral Director: After this certific filled in by the funeral director,	Certification:	4 Homicide	building, et	c. (Specify)				City or Tow	n, State)		
		To the Hospital or Attending Physician: The law requires that the death certif within 24 hours sterd death death. To the Funear Director: After this certificate has been signed by the attending pompletely filled in by the funeral director, page 2 should be detached for use as	dical ((Check only 2 Medica	ring Physician: To the best al Examiner: On the basis o	f examination and	Scatt cocum Vor investigati	d at the time, dat on, in my opinion,	la and plans death occurr	and due 15 the red at the time, o	ausa(s) en late and pla	d mannar as s ace, and due to	lated o the cause(s)
		ithin 2 the or the	Med	one) 29b. Signature and titleyof certification	and manner st	ateU.		9c. License numi	ber		29d. Date s	igned (Month,	Day, Year)
4		FIFE) -11	Mh M			RES O	00		MARC	CH 23	2007
	6	A		30. Name and address of person	on who completed cause of c	leath (Item 23a)	Type, Print)				700-75		
	9			GOODSAMAA				AVEN B			ORE	MA2	1239
	. 19	Sta	ate	31. Date filed (Month, Day, Yea		ar's Signature	A						
		Regist	rar	BARD 9 (2007 /	A Part of	mounts!						

DHMH 17 Rev 1/2001

Registrar

State

31. Date filed (Month, Day, Year)

MAR 2 9 2007

. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend #30, per DVR, 6865, 3/29/07 TT Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 Year **Physician** MARCH 26 9:55 P **EUZENT** BERNICE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY MONTGOMERY HOSPICE-CASEY HOUSE ROCKVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign Birthpiac Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🙀 F 02/07/1923 84 216-12-5278 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Director MD MONTGOMERY GAITHERSBURG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 9701 FIELDS ROAD 20878 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc □Yes 2 No Yes, Give WHITE 1 ☐ Never Married 2 ☑ Married 1□Yes 2Mo Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STERN ALPER FANNIE LOUIS ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9701 FIELDS ROAD- GAITHERSBURG, MD 20878 <u> SIDNEY EUZENT / HUSBAND</u> 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition HAR ZION TIFERETH ISRAEL 03/28/2007 BALTIMORE, MD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER METASTATIC /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending r IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 5 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 HOther (Specify) HOSPICE 1 ☐ Yes 2 💢 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မှ After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3-27-2007 puthia m Dellioms DO H0058032

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Mary Williams, DO-Montgomery Hospice-Casey House Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:00P M 2007 Avie Watts Franklin March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City, Town or Location of Death **Examiner** Anne Arundel Genesis Eldercare Severna Park Severna Park 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year May 13, 1928 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 F 78 231-52-5098 Yrs. Virginia Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location in than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Severna Park 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21146 **USA** 10 Belleview Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status e filed within 72 hours after d il Hygiene. other than "natural", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) L.P.N. Hospital permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other it any injury or other traumatic event, ITE ODICE. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Phillips Mazie Pendleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Belleview Drive Severna Park, Maryland 21146 Joanne Taylor, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 03/28/07 Baltimore, Maryland Metro Crematory Inc. ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee
Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician yocardia minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 has 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No No ieral Diractor: After this filled in by the funeral di 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Diractor: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide o the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D50725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterans Hwy Millers, 1/e MD 21108 Jenniter Kiedinger

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 9 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #18 Per FH G865 3/29/07 Certificate of Death Reg. No. Reg. No. 003 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Billy 10:04 AM March Leroy Fridac 2007/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Citi Sinai Hospital of Baltinere if Under 1 Year | If Under 24 Hs. Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 □ F Yrs. 220-76-914 Aug, 20 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No Ma Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 heyworth 2900 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: Black Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☑ Divorced Completed by 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Contractor 25 18. Mother's Name (First, Middle, Maiden Surname)
Gardine 17. Father's Name (First, Middle, Last) Be Friday olmas ဥ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Aで中井ちみ 19a. Informant's Name/Relationship (Type. Print) Baltimore Frankford Are Morner sardine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ZION Cemetery 28/07 LansdowNL 4 ☐ Donation 5 ☐ Other (Specify) - Harris Funcial Home 21. Signature of Funeral Service Licensee 22. Name and Address of Flacility (Inatma N 4210 Belair Bd Baltimore Harris ero 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Middle cerebral Artery Ischemic Stroke 13 days Physician Massive /Medical 10 years **Examiner** cocaine abuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No DIABETES MILLETUS autopsy performed 1□ Yes 2No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PAS# 19434 March 21, 2007 MMW Anupama Dorauswamy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m A ruparra Dorauswarry, (MU), St. Date filed (Month, Day, Year) 32. Registrar's Signature Simal Hospital of Balkimore 31. Date filed (Month, Day, Year) State MAR 2 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For Amend #30, perDVR, G865, 3/29/07 TT Certificate of Death

Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MARCH 25, 2007 GORDON H. GILLISS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ALLVIEW COURT CATONSVILLE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X**XM 2□ F 1915 MARYLAND Director 23, 91 705-10-2080 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f shov the Medical Examiner must be notified at 1 TYes 2X No Director MARYLAND BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō death with UNITED STATES or items 23a 409 ALLVIEW COURT 21228 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner ana. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2\times No Specify: 3 Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE WORKER DEFENSE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY GILLISS ELSIE GILLISS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAY GILLISS / SON 409 ALLVIEW COURT CATONSVILLE, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date MARCH 29, 2007 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation / 15 ☐ Other (Specify) LOUDON PARK CEM. BALTIMORE, MD 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME P.A.
421 CRAIN HWY. S.E. GLEN BURNIE, MD 21. Signature of Funeral Service Licensee 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to gras a consequence of): **Physician** 8mo /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Mesidence 6 Other (Specify) Hospital: 1 Yes XXNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ၉ After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation ieral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 T Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Dire 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 035251 MARCH 26, 2007 s of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Carole Brennan Miller

31. Date filed (Month, Day, Year)

Baltimore, MD

More St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Department of Laster Registrer State of Maryland / Department of Certificate			iene _{eg. No.} 007 09940
I	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Antoinette J. Gostomski		2. Date of Deat Month MArch	Day 2007 3. Time of Death 1:00a M
	Examin Funeral		Franklin Woods Nursing Center Bal 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1. Months E	timore Year If Under 24 Hrs. Oays Hours Min.	8. Date of Birth (Month, Day,	Year) Country)
	Director show	or	218-40-1601 10 98 98 98 98 98 98 98 9		Oct.9	,1908 Maryland 10d. Inside City Limits 1□Yes 2□No
	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show the Madical Examiner must be notilied at	by Funeral Director	10e. Street and Number 9109 Santa Rita Road 2	21236	Ţ	Og. Citizen of What Country?
900	ours after des ral', or items Examiner m	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Wildowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ Yes Give Year or Dates: 13. Was Decedent If Yes, specify 1 □ Yes 2 □ Yes Year or Dates:	nt of Hispanic Origin? (Spec Cuban, Mexican, Puerto F No Specify:	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	filed within 72 ho Hygiene. other than "natu ent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th 16a. Decedent's Usual C (Rive kind of work of the DO NDT use of the DO NDT	done during most of workin retired)	g	16b. Kind of Business/Industry Own home
Maryland 3	should be filed ind Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Joesph Jaworski	18. Mother's Name Justin	a Tipo	
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		Stephanie Custer 20a. Method of Disposition 1	nta Rita Ro of proface) Di natory 3/26 Address of Facility 3/0	oad Balate 5/07 0 MAce	ltimore MD 21236 20c. Location - City or Town, Slate Baltimore MD a Ave. Balto. MD b of Essex 21221
1760,	eath certificate be executed attending physician and attending physician and for use as the burial-transit	icai Examiner	23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any least of underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	sement A		Interval Between Onset and Death
.O. Box 68	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (special contents)			23d. Date of delivery Month Day Year
<u>α</u>	w requires that the debeen signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I.		bacco use contribute to the cause of death?
al Records,	The law ate has b page 2 sl	Completed		26. Place of Death		prior to completion of cause of death? 2000 1 Yes 2 No
ion of Vital	ng Phys fter this ineral dii	ation: To Be	2 Accident investigation M	Other: 4 Nursing Hon Linjury at Work? 1 Yes 2 No	ne 5 □ Resid 28d. Describe h	ence 6 □Othe <i>r (Specify)</i> ow injury occurred
Division	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ai Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, obuilding, etc. (Specify) 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occurred at	the time, date and place, a	City or Tow	cause(s) and manner as stated.
/	To the Ho within 24 to To the Full completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated. 29b. Signature and tyle of certifier 29c. 1	n my opinion, death occurre		29d. Date signed (Month, Day, Year)
	Sta	ite	30. Name and accress of person who completed cause of death (Item 23a) (Type, Print) Tode Workers MD 7845 OAK-We 31. Date filed (Morky, Day, Year) MAR 2 9 2007	ood Road	6 len	Pournie MD 21061

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27, 2007 Month 2:45 Am Physician Dorothy Evelyn Godshalk March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Future Care Chesapeake 8. Date of Birth (Month, Day, Year) Arnold If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Massachusetts 206-30-3615 1.01 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 No 28a-f sh notified Anne Arundel Arnold Funeral Directo Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Item 27 is marked other than "natural", or items 23a or other traumatic event, the IM-dical Examiner must be re-21.01.2 USA 305 College Parkway death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White altimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental H Be Herbert Smith M. Irene Markeley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) of Health a item 27 is 243 Orchestra Place Centreville, Maryland 21617 Shirley A. Clark, Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H
Important; if Ite
any Injury or of
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 03/27/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PORPAST CANCER METASTATIC VOARS **Physician** /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physiclan ar s the burial-t Box 68760. attending phy IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death P.O. | 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 | Yes 2 No 3 | Probably 4 Unknown DOMONTIA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha performed 1∐ Yes 2 No Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28h Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number

29d. Date signed (Month, Day, Year)

PAG360

MARCH 27, 2007 29b. Signature and title of certifier

St

DHMH 17 Rev 1/2001

State Registrar

MAR 2 9 2007

1 CHAEL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #26, perMD, g865, 3/29/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200^{Year} Physician 23 MArch PM5:50 Edward Huntt Hall, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 2318 Dunwood Lane Joppa Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 4, 213-28-1310 76 1931 Maryland Feb. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Selbyville Delaware | Sussex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 19975 U.S.A. 37054 Blue Teal Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 💆 No þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 ho Health and Mental Hygiene. Iem 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) BGE Utility Supervisor 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Be Elsie Huntt ၉ Gordon Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 207 Holy Cross Road Street, MD 21154 Phyllis Sturgill (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 6 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/27/2007 injury (Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Rd. Bel Air, MD. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final eus resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown s been signed by should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Be Completed 24a. Was an

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Hall, Edward

certificate has birector, page 2 s this funeral After neral Director: /

ပို

Certification:

Medical

State Registrar 29a. Certifier

(Check only

Division or Vital Records, P.O. Box 68760,

autopsy performed? Yes No 1∐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Hospital: 1 ☐ Yes 20 No 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Son's Residence
(Specify) 28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print) exchal Hagling Facust Taland De 19944

31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

To the Funeral completely filled within 24 hours

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤌 🕦 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** HILLZ PM EMANUEL 2007 BERNARD HILL 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORK LTR MED BALTIMORE VA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days Maryland 13-26-8076 1**X** M 2□ F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examinar investible notified at 1 XYes 2 ☐ No Director saltimore. 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Balto City Sanitation Dept. Pages 1 and 2 should be filed vent of Health and Mental Hygie out: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Contee 19a. Informant's Name/Relationship (Type, Print) (nephew) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other p Department of Health Importent: If item 27 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/30/200 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 0500 L. Russ 21. Signature of Funeral Service Licensee 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE Approximate Interval Between Onset and Death Physician /Medical **Examiner** SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably HYPOALPUMINEMIA, EMBOLISM, Completed 24b. Were autopsy findings available prior to completion of cause of death? THROM BOLYTOPENIA ANERIA autopsy 2 XNO 1 Tyes of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Yes 2 No ျှ 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Certification; Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Diractor: after within 24 hours a To the Funeral (

SEFF 31. Date filed (Month, Day, Year) MAR 2 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29a. Certifier

Medicai

State

Registrar



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

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29d. Date signed (Month, Day, Year)

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G ₁	/Medic Examin	100	4a. Facility Name (If not institution, give	street and number)	May	4b. City	, Town, or	Location of		1011		. County of			
	LXanini		Laurel Regional	Hospital	,]	Laure	1				rince	Geo	rge's	
	Funeral		Social Security Number 6. Se		yrs. last birthday)	If Unde Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date 18			Count		
18 fac	Director		245-42-6484 Usual Residence of Decedent	X W Z	-80 OILus				Ī	Jan. 🛨	, 19	27 No	orth	Carol	ina
	land ow It		10a. State 10b. County	100	c. City, Town or Lo	cation							10	d. Inside Cit	y Limits
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	th the	Jirec	10e. Street and Number			10f. Z	ip Code				10g. Ci	tizen of Wha	t Count	ry?	
	23a cust b	Funeral Director	501 Lakeford Road				209					US <i>I</i> 14. Race -		n Indian	
	er deg	nue	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Dec If Yes, sp	edent of H ecify Cuba	ispanic Ori an, Mexicar	igin'? (Spec n, Puerto F	cify Yes or N Rican, etc.)	0-		White, e		
36	irs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes	2X No	Specify:				Specify:	Whi	te	
9	2 hou	ted	15. Decedent's Edu (Specify only highest grad	(cation	16a. Dece	dent's Us	ual Occup	ation during mos	t of workin	a	16b. l	Kind of Busin	ess/Ind	ustry	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	life.	<i>bo not</i> 7eyo1	use retired	1)	a or worth.	9	De	pt. of	De	fense	
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nor	ages int of l t; if ltd / or o		1 ☐ Burial 2 ☐ Cremation 3 🔀		cemetery, cre			1	2/20/	(2007	Co	unail	NC.		
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any injury or other tra once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License		Mt. Horek			Y ; ss of Facili	3/30/ by Do	onalds		uncil, uneral		me, P.	Α.
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	/Medical Examiner		resulting in death)	Due to (or as a con		Dia								vears	
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o,	an an	ш.	resulting in death) Last	Due to (or as a cor	nsequence of):										
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Vital	Physician: this certificatal director, p	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or.		Check onl					-
0	Phys r this ral dii	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 X ER/Outpatie		28c. Inju: Woi	4 🗆 N		ne 5 Re 28d. Describe				/)	
on	nding th. ? Afte e fune	tion	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury	M		rk? Yes 2□]No						
Division or	or Atter	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, st	reet, fact	ory, office		2	28f. Location City or T			or Rura	l Route Nun	nber,
7	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Ce	29a. Certifier 1 🛣 Certifying Ph	ysician: To the best of m niner: On the basis of exa and manner stated.	amination and/or i	th occurr nvestigat	ed at the ti on, in my	me, date a opinion, de	and place, a	and due to the ed at the tim	ne cause e, date a	(s) and manr nd place, an	ner as s d due to	tated. the cause(s	s)
(4)	o the vithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.		- 2	29c. Licens	se number			29d. D	ate signed (Month,	Day, Year)	
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λ	T		30. Name and address of person who	A	(Item 23a) (Type	, Print)	עד.	/ 0 / 4			1,10	11 CII Z	0,	2007	-
IJ			S.M. Nayar, MD	3717 .38th	Avenue.	Cott	age (City,	MD	20722					
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 9 20	3 Registrar's	Sign Arre										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 28^{ay} 8:10 ам 2007 **Physician** Hayes Mary D. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
13804 Manor Glen Rd. 4b. City, Town, or Location of Death Examiner Baltimore Baldwin If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min 1□M XX F 218-18-4739 91 Yrs 12-24-1915 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified a once. Harford Baldwin 1 ☐ Yes 2 🗶 No MD. Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 13804 Manor 21013 Glen Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify WHITE Baltimore, Maryland 21215-0036 Specify: þ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Associate 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valerie Sarandakas Harry Doukas ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13804 Manor Glen Road, Balgwin, Maryland, 21013 G. Hayes Christain 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩Burial 2 Cremation 3 Removal from State Angel Hill Cemetery 03-30-2007 Havre De Grace, MD. 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} uneral Home, Inc. 1050 York Rd. Towson, Md. 21204 21. Signature of Funeral Service Licensee R. H. Buz — (R.G.Ruth) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart **Physician** disease or condition resulting in death) YEUV /Medical **Examiner** Sequentially list conditions, if any local good from Junior Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Obstructive Viscasc 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hypertension
25. Wa case referred to medical examiner? 1 ☐ Yes 2 ☐ No 26. Place of Death Check onl o e Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? s after death. 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Natural 1 TYes 2 TNo 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Hlexander 32 Registrar's Signature 31. Date filed (Month, Day, Year) Belle MAR 29 2007 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth Month **Physician** 23 2007 11:54 pm 3 Jerry R. Jones, Sr /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center # Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 3-23-1948 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 1QM 2□ F 59 FL Director 263-80-2995 Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location If itsm 27 is marked other than "natural", or items 23s or 28s-f show or other traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Anne Arundel Μđ Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21144 1817 Graybird Ct 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 12 Yes 2 □ No 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1□Yes 2□No Specify: Specify:Black If Yes Give 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Post office Postal Worker 12th grade NA Demit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyol important: If item 27 is marked any injury or other. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elvira Woods Cubit Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Graybird Ct Severn, MD 21144 Gabriele Jones - Wife 1817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Nation 3 ☐ Removal from State Crownsville, MD Crownsville Veteran 3-29-07 4 Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Econsee 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Myocardial Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examine ettending physicien end for use es the burial-trensit Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Nos 2□ No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed TLIYOS 2 NO 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Aftert 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide filled in by 4 Homicide 6 within 24 hours a

To the Funeral D

completely filled To the Hospital edical ts. Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cuttfler (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1941617 Mar 26, 2007 Kay 30. Name end eddress of person was completed cause of death (Item 23e) (Type, Print) re Rollapundis Med 21049 10805 GaryKazlow Hickory Rid

Registrar DHMH 16 Rev 6/95

State

31. Dete filed (Month, Day, Year) MAR 2 9 2007

DONES, JERR'

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 6:27 PM Johnson Jamere Janes 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Medical Span M Baltimore
If Under 1 Year If Under 24 H NA 5. Social Security Number Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M **X**□ F Months Days Min Director 219-90-4595 21 1977 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore 1X Yes 2 No MD NΑ Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Street Apt1005 2601 W. Madison USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ▼ No Specify þ Specify: Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) мта Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Deborah Peterson James Johnson ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Peterson -Mother 1631 Cliftview Avenue Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park3-30-2007 Randallstown, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility March East F/H Balto, 1101 E. North Avenue MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Thrombotic Thrombour topenia 5 wecks /Medical Due to (or as a consequence of): Examiner Immunoseficiency Syndrome Due to or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical SB IF FEMALE nse If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy 2 **N**0 1☐ Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name any address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 2120 31. Date filed (Month, Day, Year) State MAR 2 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Marylar	•		nt of He te of D		Mental Hy	giene Reg. No	UUI	09948
			1. Decedent's Name (First, Middle, Last						2. Date of D		v Year	3. Time of Death
	Physici Medic/		Helen Elizabe	th Johnson					Month	Day		1315 PM
1	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or l	Location of Dea			County of Death	1
			Easton Mamoria	Hospital		Ea	Ston	, mo		1	Talbot	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Unde Months		If Under 24 Hr. Hours Min		rth av. Year)		nplace (State or Foreign untry)
	Director		219-44-1920	M 2 X F 8	6 Yrs.	Monard	50,0	1,00.0	July 1	3, 1	920 Mai	cyland
	Du 🔪		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	cation						10d. Inside City Limits
	anyla shov	5		100. 01								1 ☐ Yes 2 No
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	vith II	Director	10e. Street and Number			101. 2	p Code			iug. Cit	izen of What Co	untry?
	eth v		108 North Higgins		10 140	M		21601	Const. Vac as N	_	USA 14. Race - Amer	none ladion
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	1.5.	If Yes, spi	ecify Cuban	, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	Black, White	
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21215-0036	within 72 hours after deeth with the Maryland ene. then "natural", or items 23a or 28a-f ehow ta Maulical Exemple must be mollited at	edit	15. Decedent's Edu		16a. Dece	dent's Usu	ral Occupat	tion		16b. K	ind of Business/I	ndustry
5	in 72	Completed	(Specify only highest grad	e completed)	(Give	kind of w	ork done du use retired)	iring most of we	orking			,
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ğ	i Hyg othe	a	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle	. Maiden	Sumame)	
Maryland	fenta fenta rked	To B	Edmond Bray					Hele	en Samis			
ary	shound N	Γ,	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailir	ng Addres	s (Street ar		Rural Route Numi	oer, City o	r Town, State, Z	ip Code)
Σ	alth a 27 is		Mark H. Johnson	, Son	211 S	outh	Auror	a Stree	et Easto	n, Ma	aryland	21601
ē.	of He Item		20a. Method of Disposition	i .	Place of Dispo	sition (Na	me of other place)	Date	20c. Lo	ocation - City or	Town, State
E	Page nent c nt: if ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		tro Cr	emato	orv Ir	nc. 03	/28/07	Bal	timore.	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Menial Hygiene. Depertment of Health and Menial Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show arry injury or other traumatic svent, it is Medical Examinat or unit to notified at once.		21. Signature of Funeral Service Ligens						Of Mary			
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e e	Physician		Immediate Cause (Final disease or condition	Q (# 0	. (,	· ~_<	2				Onset and Death
	/Medical		resulting in death)	Due to (or as a consec								
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9	ng ph ng ph	Wed	IF FEMALE:									7
Вох	death certifi e attending id for use as	an/I	23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic p	regnancy			l li	23d. Date of deli Month	very Day Year
	ed fo	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of of 9☐ Unknown	death 5	Other (s	pecify)				Wichter	Day
<u>Р</u> О	at the	문	9 Unknown						00: 014			the course of death?
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Ξ	l or Att after d Direct I in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, facto	ry, office			(Street an wn, State		ral Route Number,
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	thin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.		29	c. License	number		29d. Dat	te signed (Monti	n, Day, Year)
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	P		30. Name and address of person who co				Charact	⊢ 17	- M1	- J	21601	
	()		Dennis DeShields 31. Date filed (Month, Day, Year)	219 South W	ature A		orree!	L <u>rasto</u>	u, Maryl	.and	ZTOUT	
	Sta Registr		MAR 2 9 200	2. Registrar's Sign	ature	all.						

Johnson, Helen

			y <mark>pe or Print in</mark> State of Maryla						ole.	0010
	•	1 - For State Registrar	-	Ce	rtificate	of Death		Reg. No.		09949
Physici		1. Decedent's Name (First, Middle, Last) HANNAH , 31	GGETTS				2. Date of De Month	ath Day 22	Year 07	3. Time of Death 4:30 A M
/Medi Examir		4a. Facility Name (If not institution, give st GOOD SAMARITA	reet and number)	-	BAL	wn, or Location of Death	1	4c. County	/A	
Funeral Director		240,40,4100	7. Age (In yi	s. last birthday Yrs.	Months [Year If Under 24 Hrs. Days Hours Min.	8. Date of Bir (Month, Da 12.18	th 1925	9. Birthpl	lace (State or Foreign try) NC
Aaryland I ehow	or	Usual Residence of Decedent 10a. State 10b. County A	10c.	City, Town or L	ocation More				10	0d. Inside City Limits 1 Yes 2 □ No
with the had a or 28e-	Funeral Director	10e. Street and Number 5613 Carter A	henue.		10f. Zip C	21214		10g. Citizen of V	Vhat Coun	try?
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and 2 should ealth and Me n 27 le mark	To	19a. Informant's Name/Relationship (Typ	o. Print) Grand Daughter	1 1	ling Address (Street and Number or Re		er, City or Town,		Code)
caltification of mit. Pages 1 and partment of Health portant: If item 27 y injury or other tr.		20a.Withod of Disposition 1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	amoval from State	. Place of Disc	oosition (Name ematory or oth	of er place)	Date 28 07	20c. Location -		
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Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	TATIC		of dying, such as cardia		arrest,		Approximate Interval Between Onset and Death
	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons							
The Colids, T.O. BOX 00100, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pre				te of delive	ery Day Year
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To the To the Comment of the the the the the the the the the the	Σ	29b. Signature and title of certifier Tween			1	License number		29d. Date signe	2,2	
5		30. Name and address of person who co	mpleted cause of death (Item 23a) (Typ	e, Print)	LVD , BALT	MORE,	MD 21	239	
St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 9 200	32 Registrar's Si	gnature	ark					

MAR 2 9 2007

				State of Maryland	d / Depa		Health and M		ene	0.7	00050
			State Registrar		Ce	rtificate of	Death		g. No.	U /	09950
- XX	Physici /Medic		Decedent's Name (First, Middle, Last)	ROBERT	Μ.	JOHNSTON		2. Date of Death Month MARCH	26, 20		3. Time of Death 2:55 P.M
	Examin	er	4a. Facility Name (If not institution, give st BLAKEHURST CARE	reet and number) CENTER			WSON		4c. County	of Death	MODE
	Funeral	\u03'	5. Social Security Number 6. Sex	7. Age (In yrs. la	ıs <i>t birthd</i> ay)			8. Date of Birth	I .	9. Birthpla	ace (State or Foreign
L	Director		040-22-6309 Usual Residence of Decedent	M 2□F 80	Yrs.	Months Days	Hours Will.	8. Date of Birth (Month, Day, 10-08-1	926	CONN	VECTICUT
	e Maryland 3a-f show tified at	ctor	MD. 10b. County BALTIMO		, Town or Lo		HERVILLE				d. Inside City Limits 1 □Yes 🏋 🛣 No
	h with th	al Dire	10e. Street and Number 6 BROOKLANDRIDGE	ROAD		10f. Zip Code	21093	10	g. Citizen of V	S. A.	-
036	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medie at Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married XIX Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes W No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes XX No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America k, White, e :: WH]	tc.
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Baltimore,	ges 1 and It of Healt If Item 2: or other		20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Re	ce	metery, cre	osition (Name of matory or other pla	ce)	i	Oc. Location -	-	
Ē	permit. Pages Department of Important: If It any injury or o		4 □ Donation 5 □ Other (Specify)	111		SERVIUE 2. Name and Addre	CORP. 03-	28-200 <i>1</i>	TOWSON	I, MAR 150 YO	
Ra	Depa Impo any li		21. Signature of Funeral Service License	(R.G.RUTH)			ON FUNERA	L HOME,IN	10		MD.21204
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death of cause on each line. Glibblash Du to (or as a consequ	ma	ter the mode of dyi	ng, such as cardiac	or respiratory arre			Approximate Interval Between Onset and Death WWMWS
	Examiner	<u>_</u>	Sequentially list conditions, b.	Due to (or as a consequ	ence of):						
760,	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence							
6876	e % e	edical	d.								_
O. Box 6	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome pf pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	y		1	te of deliver	ry Day Year
1	ires that the de signed by the a t be detached to	y Phys	Part II. Other significant conditions cont	1 1		inderlying cause gi	ven in Part I.	23e. Did toba	acco use cont	ribute to the	e cause of death?
ord	w require been sig should b	ted k	Chrine Cympl	rcytic leuke	Ma			1 ☐ Ye	s 2 No	3 ☐ Proba	ably 4 ∐Unknown
al Records,		Completed by							ed?	prior to com death?	osy findings available upletion of cause of 2 No
· Vital	ysiclar s certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatie	nt 3 DOA Oth		h <i>(Check</i> o <i>nly</i> one me 5 ☐ Resider		er (Specify)
Division or	ing After uner	1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ry at	28d. Describe hor			,
DIVIS	after dea after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At hor building, etc. (Specify)	me, farm, st)	reet, factory, office		28f. Location (Str. City or Town,		er or Rural	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Medical C		ician: To the best of my know er: On the basis of examinati and manner stated.							
)	To the within To the comple	Me	29b. Signature and title of certifier 30. Name and address of person who con Amount of the control of the con	w)		29c. Licens	se number	29	d. Date signe	d (Month, I	2-00 7
	10		30. Name and address of person who cor	inpleted cause of death (Item	23a) (Type,	Print) Charle	es Sr 7	DNSON.	m) 2	1200	+
_/			31 Date filed (Month Day Year)	32 Fegistrar's Signat	101 1	0 00 00	- 01 1	,			

31. Date filed (Month, Day, Year) MAR 2 9 2007 State Registrar

32. Segistrar's Signature

Soules

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Kolar 3 M March atherine 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore University of Maryland Medical Center nla If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 22, 19 Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 ☐ M 2 🗓 F 1914 Maryland 92 Dec. Director 212-05-0182 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Directo Harford Bel Air Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "nature" any Injury or other traumating. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21014 953 D Redfield Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Otto Joseph Lohr ဂ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 555 Trimble Road Joppa, MD 21085 Donna Lohr (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Bunal 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Bel AirMemorialGarden 03-29-2007 Bel Air, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee 610 W. Macphail Rd., Bel Air, MD. 21014 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ematomo Physician CERTIFICAL ASPROALED BY INCIDENCE LEVANIES /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical a IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ij 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 3:00 P M 1 Natural 5 Pending investigation SUBJECT HAD FALL 1 ☐ Yes 2 No 24 hours after death. • Funeral Director: # 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) BRIGHTWEW SENICE CIVING 4 Homicide COMPLEX FALL MAD LIVING 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tixe of certifie 1476435-1804

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16

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

Ulmer

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31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Keesee 1750 M **Physician** March 26 James 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** AUGUST 18, 1944 Director 62 103.36.4447 Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2□No Director NC PENDER HAMPSTEAD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or be "natural", or items 23a USA 1013 HIGHLANDS DR. 28443 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

**M2 Yes 2 □ No If Yes, Give Year or Dates: 1963-65 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAW ENFORCEMENT POLICE OFFICER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PHYLLIS PIVARNICK ျှ JAMES E. KEESEE, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1013 HIGHLANDS DR. HAMPSTEAD, NC 28443 MARY C. KEESEE WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any Injury or or 1XX Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4.2.2007 CALVERTON, NY ~CALVERTON NATIONAL CEM 21. Signature of Juneral Service Lic 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT
426 CRAIN HMY S. GLEN BURNIE, ND. 21061 GREGORY FINK ĸ. Part1. Enter the discusse, it compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it heart failure. Let only one cause on each line. 23a Part1 Immediate C use (Final disease or co cition resulting in dea **Physician** Ischemic Cardiomyopathu 5 years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 2 No To the Hospital or Attending Physiclan; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Medical Doctor HOW Res-000 March 26, 2007 IMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miya Paterniti, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore Maryland 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 2

Carrie Contract

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Year Month 2007 Kosa 1 aru e 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 5. Social Security Number tagerst Washing 8. Date of Birth (Month, Day, Year) If Under Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace Country) 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 1 F August 1, 218-30-7774 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 4 Yes 2 No Hagierston Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20740 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ♣ If Yes, Give Year or Dates: 2[DNO 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vurst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sm Mill Dr. Mousansville W e 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Saltimore, MD etro Crematory 4-2-07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Facility 21. Signature of Funaval Service Licens Midvalla 18434 17.4W 1330 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAL appl nun Due to (or as a consequence of): ONGESTWE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): MASSIVE Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1☐ Yes 2 1 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be executed for use as the burial-tran Division or Vital Records, P.O. Box 68760 attending physician signed by the at d be detached fo page 2 s has certificate or Attending Physician: this completely filled in by the funeral After death. after death

Physician/Medical Examiner Completed by Be Medical Certification: To

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be 2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Saltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 27. Manner of Death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RADIR

20311 LOAD BOOMSBOND

State Registrar

31. Date filed (Month, Day, Year) MAR 2 9 2007



To the Hospitai within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 8:28 AM 2007 Bryan 03 Michael 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center University of Maryland Medical Baltimore, Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months **XX**M 2□ F 46 Director 04/17/1960 214-82-0494 MD 10c. City, Town or Location 10d. Inside City Limits 10a. State a or 28a-f show t be notified at 10b. County Yes 2□No MD Baltimore City Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a USA 21224 22 North Curley St. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ANNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify. Specify: White 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Valley Painting CO. Painter 12 permit. Pages 1 and 2 should be filed be partment of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Calvin Knatz Patricia Ann Buckler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 151 North Decker St., Baltimore, MD 21224 Kimberly N. Knatz / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 03/29/2007 Odenton, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rendon-Bailey Funeral Home, PA M01452 2818 E. Baltimore St., Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner HIV / AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-tran Due to (or as a consequence of): attending physician Box 68760. Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy erformed' or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospital c within 24 hours aft To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier

State Registrar S. Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

32. Registrar's Signature

Frosch, MD

31. Date filed (Month,

2 9 200

P21190

Street

03-24-2007

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1. Decedent's Name (First, Middle, Last) Physician Medical Examiner Madhusudhan Rao Kancharla 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	2. Date of Death	g. No.
4h City Town or Location of Des	March	Day Year 7 1455 fm
	ath	4c. County of Death
Union Memorial Hospital Baltimore Funeral 5. Social Security Number 6. Sex WM M 2 F 7. Age (In yrs. last birthday) Months Days Hours Min Months Days Hours Min	(Month, Day,	n/a Year) 9. Birthplace (State or Foreign Country) Country
Director 187-32-8635 Usual Residence of Decedent	June 5,	1933 India
10. Oh. Taranianian		10d. Inside City Limits 1
Maryland Howard Ellicott City 106. Street and Number 106. Zip Code	10	Og. Citizen of What Country?
Maryland Howard Ellicott City Maryland Howard Maryland Howard Maryland Maryland Howard Maryland Howard Maryland Howard Maryland Howard Maryland Howard Maryland Howard Maryland Maryland Howard Maryland Maryland Howard Maryland Maryland Maryland Maryland Maryland Howard Maryland Mary		United States
The second secon	Specify Yes or No-	14. Race - American Indian,
The part of the pa	эпо нісап, екс.)	Black, White, etc. Specify: Asian-Indian
15. Decedent's Education 16a. Decedent's Usual Occupation	norking 1	16b. Kind of Business/Industry
Second Second	Orking	
State 5 5+ Business Man		Publicity
Top of page 1 to the page 2 to	ame (First, Middle, N	
The state of some (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mother's Name (Part Name (First, Middle, Last)) 18. Mother's Name (Part Name (Part Name) (Type, Print) 19b. Mailing Address (Street and Number or Name) (Type, Print) 19b. Mailing Address (Street and Number or Name) (Type, Print) 19c. Informant's Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print) 19c. Name (Part Name) (Type, Print)		velamudi
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or in the street and Num		
Gayatri Devi Nimmagadda/daughter 11639 Vixens Path E		ity, Maryland 21042 20c. Location - City or Town, State
1 Rurial 2X Cremation 3 Removal from State	28/2007	Odenton, Maryland
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral	Home & C	rematory, P.A.
23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	iac or respiratory arre	on, Maryland 21113 Approximate
Physician Immediate Cause (Final disease or condition resulting in death)		Interval Between Onset and Death
Examiner		·
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
resulting in death) Last Due to (or as a consequence of):		
d		
X = 5 5 6 7 7 7 7 7 7 7 7 7		23d. Date of delivery Month Day Year
O o the first of the condition of the co		pacco use contribute to the cause of death?
	24a. Was ar autops perform	y prior to completion of cause of
The state of D on the state of	1 Yes 2 Peath (Check only one	
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing		ence 6 Other (Specify)
25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of D 26. Place of D 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No	28d. Describe ho	w injury occurred
To the state of th		
To be the control of	28f. Location (St. City or Town	reet and Number or Rural Route Number, n, State)
	courred at the time d	ate and place, and due to the cause(s)
27. Manual of Death 1		
The state of the s	2	9d. Date signed (Month, Day, Year)
29a. Certifier 29a. C	46	3(27/2007
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Pegistrar MAR 2 9 2007	46 22	9d. Date signed (Month, Day, Year) 3(27/2007)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) al c **Physician** 2007 3:40 AM Doris Gail Lathe ARCH /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen instan Hidical If Under 24 Hrs. Age (In yrs. last birthday)
59 Yrs. If Under 1 Year 8. Date of Birth (Month, Day, Ye April 15, 9. Birthplace (State or Foreign Country) Mary Land **Funeral** Days 214-54-1930 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 505 Stewart Avenue 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Marylahd 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Electric Co. Operator 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Berlin Doris Geary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5647 Harbor Valley Drive, Baltimore, MD 21225 Kimberly Cooper/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 3-28-2007 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 21. Signature of Funeral Service Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or commitatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Touwre **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed attending physician and for use as the burial-transit Examir Due to (as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the g□Unknown g ☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After (Month, Day Year) 5 ☐ Pending investigation Injury 1 Natural 2 Accident 1 ☐ Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Box 68760, P.0. Division or Vital Records, To the Hospital

State

Medical

29a. Certifier

(Check only one)

Registrar

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0

31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deat 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** John Henry Layton March 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Agues Hospita Baltimore
Year | If Under 24 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Apr. 12, 1 5. Social Security Number 220-36-2021 If Under 1 Sex ‡⊾M 2□F 7. Age (In vrs. last birthday) Funeral Days Months Hours 67 1939 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Arbutus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5602 Braxfield Road 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 12 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed <u>Retail Sales</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Louis Layton Evelyn Honora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam Layton - Wife 5602 Braxfield Rd., Arbutus, MD 21227 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 □Cremation 3 □Removal from State 4 Donation 5 ☐ Other (Specify) Parkwood Cemetery : 3
22. Name and Add ess of Facility 3-29-2007 Baltimore, MD Sign to Oof Funeral Service Licensee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 10-20years **Physician** Atherosclerotic Connary Vancolar Distant disease or condition resulting in death) /Medical Que to (or as a consequence of): Examiner 20y6125 Arabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): certificate be Physician/Medical as signed by the attending | I be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Hr/hythmin) funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No
27. Manner of eath Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funeral Director; A completely filled in by the fi 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Division or Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Michelle 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

mU Registrar's Signature 900 Capu Avenue Battoner, Mb 21229 case

29c. License number

29d. Date signed (Month, Day, Year)

March 25,2007

07-02239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Latoya Lee 1. For State Certificate of Death Rea. No Registrar

1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day March 23, 2007 1335 hrs **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Maryland General Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Min Months Days Country)MARVLAND Director M 2▼F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 No 28a-f shov tant: If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at once. with the Maryland Director log. Citizen of What Country? 10e. Street and Number Funeral Race - American Indian, Black Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes Yes 2 No specify: If Yes, Give Year Specify: Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hent of Health and Mental Hygiene ALTO CITYCHILD SUPPORT MINISTRATIVE THGRAND 17. Father's Name (First, Middle, Last) EE :00 K Be IMOTHI (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relati ship (Type, Print) 19b. Mailing Address NORFOLK MOTHER 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Other Specify se and Address of Facility BROWN . FUNERAL BALTO.ML 21. Signature of Funeral Service Licens HOME I/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a Pneumonia associated with ketoacidosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Diabetes mellitus Sequentially list conditions Due to (or as a conse wence of) Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical X UNPENDED ^{AME} 23a b,27, per ME, g867, 5/15/07 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) i signed by the atte 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. P.O. Part II. Other significant conditions 1 Yes 2 V No 3 Probably 4 ģ Unknown Completed of Vital Records, 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 page To the Hospital or Attending Physician: The certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 Z ER/Outpatient 3 Nursing Home 5 Residence 6 DOA After this 1 🗸 Yes 2 28b. Time of Injury 28c, Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Manner of Death Certification Division 1 X Natural 1 Yes 2 No Pending death. Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide 3 Could not be determined 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the l and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certific sall O.C.M.E. March 24, 2007 Murie 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD Assistant Medical Examiner Registrar's Signature 31. Date filed (Month, Day, Year) State

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

MAR 2 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 20 2007 /Medical 4c. County of Death 4a, Facility Name (If not institution, 4b. City, Town, or Location of Death give street and number Examiner N/A Johns 8. Date of Birth (Month, Day, Year) 11/16/1948 5. Social Security Number Birthplace (State or Foreign Country) **Funeral 1**℃ M 2□ F 58 216-50-2482 Yrs. MARYLAND Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ns 23a or 28a-f show must be notified at 1X Yes 2 No MD N/ABALTIMORE CITY Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1701 EUTAW PLACE, APT. 21217 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. items ? 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married ò Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GROCERY CLERK SUPERMARKET **9TH** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be marked HALLIE LEE VIRGINIA LEE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S 1701 EUTAW PL, APT. 923, 21217 Item 27 SYLVIA LEE / SISTER BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or c 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 3/29/07 METRO CREMATORY CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 uneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, se, or complications that caused the deat... o not enter the mode of dying, such as cardiac or respiratory arrest, Enter the also ck, or he we allo Cause (Final **Physician** disea or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-trar Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2 **1**No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Miya 31. Date filed (Month, Day, Year, MAR 2 9 2007 Registrar

luja

Paterniti

Medical Poctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. BAHIMORE, MARY LAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 2007 ELIZABETH M. LIEBENTHAL 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Unrni Banna Mashon Madela If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Min Hours 1 □ M 2 ■ F 1931 75 08 215 28 9646 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No 106 Disney Ave Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 106 Disney Ave 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vernon Seubott Helen Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond Liebenthal/husband 106 Disney Ave Pasadena, MD21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crestlawn Mem Gdns 3/29/07 Marriottsville, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Dr. Pasadena, 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a c V. Due to (or as a consequence of): IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 21 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

the Medical

other than

Item 27 is marked other other traumatic event,

Ö Department o Important: If any Injury or

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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MD

Examine attending physician and for use as the burial-tran Physician/Medical Completed by page 2 Be မ this funeral Medical Certification:

requires that the death certificate be executed

Attending Physician:

To the

after death the

within 24 hours a

To the Funeral I

completely filled

in by

ō

Division

Vital Records, P.O. Box 68760

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Part II. Other significant con	ditions contributing to death b	out not resulting in the und	derlying cause given in Part

26. Place of Death (Check only one)

25.	Was case examiner	?	to	medica
	1 ☐ Yes	2 No		

27. Manner of Death 1- Natural 2 Accident 3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

npatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

2 ER/Outpatient 3 DOA 28c. Injury at Work? 1 TYes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

BUR 31. Date filed (Month, Day, Year)

9 2007 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State	State of N				t of H	ealth a			giene		09961	
		770	Registrar 1. Decedent's Name (First, Middle, Las	1)			rinoan	0 01 1	Journ		2. Date of De			3. Time of Death	
	Physici	an	Margaret La	2							Month	21 Day	200 .	510AM	
3	/Medic Examir		4a. Facility Name (It not institution, give	street and number	er)		4b. City,	Town, or	Location of	of Death		4c.	County of Dea		
	Exami	ici	1835 Crofton	Parkwa	1 #A		Cr	ofter	1			17	Home Hondel		
	Funeral		Social Security Number 6. Security Number		Age (In yrs. I	ast birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da Oct 27	rth av. Year)	9. Bi	rthplace (State or Foreign	
	Director		218-24-0069	□M 2XF	79	Yrs.	Monard	Days	710010		Oct 27	, 192	27 Was	shington, DC	
	D .		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	neation							10d. Inside City Limits	
	ehov	'n		1 1	100.0		fton							1 □Yes 2 ☑ No	
	28a-1	ecte	Maryland Anne Art	indel		CFO	10f. Zip	Code				10a. Citiz	zen of What C	Country?	
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	ne 23	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)	0- 1	14. Race - Am		
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21215-0036	within 72 hours after deeth with the Maryland ena. than "naturel", or Iteme 23a or 28a-f ehow the Madical Exantina notal be notified at	Completed	15. Decedent's Ed (Specify only highest grade)	ucation de <i>completed)</i>		(Give	dent's Usua kind of wo DO NOT us	rk done d	during mos	t of workii	ng	16b. Kir	nd of Busines	s/Industry	
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ary	2 should and Men is marks	-	19a. Informant's Name/Relationship (7			19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Numb	er, City or	r Town, State,	Zip Code)	
	s 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hyglena. Item 27 is marked other than "naturel", or Iteme 23s or 28s-f ehow other traumatic event, the Medical Expressor must be collised at		Sharon A. Lee/dau	ghter		3023	Be11	Grov	e Dr	ive :	Րallaha	issee	, Flor	ida 32308	
J. C.	of He		20a. Method of Disposition 1 Burial 2 Cremation 3	Domoval from Sta		lace of Dispo emetery, crea	osition (Nar matory or o	ne of ther plac	e)	D	ate	20c. Lo	cation - City o	r Town, State	
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Baltimore,	permit. Peges Department of I Important: If Ite eny Injury or or once.		21. Signature of Funeral Service Licen	See		Do	2. Name an onalds	d Addres	s of Facility	ål Ho	ome & C	Crema	tory,	P.A.	
_	<u>₹</u> 0 5 3 3			roma		14	<u> 11 Ar</u>	napo	olis :	Road	Odent	on,	Maryla	nd 21113 Approximate	
			23a. Part Enter the disease, or comp shock, or heart failure. List only	one cause on each	sed the deatr n line.	n. Do not en	ter the mod	e or ayın	g, such as	cardiac o	r respiratory a	irrest,		Interval Between Onset and Death	
7	Physician		Immediate Cause (Final disease or condition resulting in death)	a	49	ance								3 Months	
	/Medical Examiner		1	Due to (or	as a colosequ	uence of):									
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consequ	uence of):									
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89)	artifica ing pt e as t	Med	IF FEMALE:												
Box	ath ce	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth	2 Fetal	Ideath 3	□Ectopic pr					2	23d. Date of d Month	elivery Day Year	
-	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnani 9□Unknowr		eath 5L	Other (sp	эеспу)							
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ds	juires n sign ald be	þ									1 🗆	Yes 2	□No 3×	Probably 4 Unknown	
000	s bee	jete									24a. Was		24b. Were	autopsy findings available o completion of cause of	
R	hysician: The law his certificete hes b I director, pege 2 si	E									auto perf 1 ☐ Yes	ormed?	death?		
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Š	Physician: this certific ral director,	ပို	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatie			4 🗆 NI		me 5 Res			pecify)	
ñ	ing P	i i	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		njury Day Year)	28b. Time o Injury	of 2	28c. Injun World	yat k? Yes 2.⊟		28d. Describe	how injur	y occurred		
Division of Vital Records,	death death stor: ,	cat	2 Accident investigation 3 Suicide 6 Could not be	1	Injury - At ho	ome, farm, st					28f. Location	(Street and	d Number or I	Rural Route Number,	
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	spite	Medical Certification;	29a. Certifier Certifying Ph												
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	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Σ	29b. Signature and title of certifier	h. Mi					e number	N/ 1.	276	29d. Dat	e signed (Moi	nth, Day, Year)	
	10			NUC 111					120	U69.	549		3/24	13007	
1	7		30. Name and address of person who	completed cause of	of death (Item	23a) (Type,	Print)	0	mlu :	MD	379 21401			v	
,	e.	ate	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ture Ann	Lis !	MILIT	714	- 32	0-1-(0)				
	Regist		MAR 2 9 200	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	and It	Par									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 2007 4:20a 27. MARCH 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. JULY 29, 1912 7. Age (In yrs. last birthday) 6 Sex 1 M 2 □ F ILLINOIS 94 10c. City, Town or Location 10b. County BALTIMORE

Physician FREDERICK ROGNALD MATSON /Medical 4a. Facility Name (If not institution, give street and number) Examiner ROLAND PARK PLACE 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 185-22-2050 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State r 28a-f show notified at 1 XYes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be not by Injury or other traumatic event, the Medical Examiner must be not be in the Medical Examiner must be not provided to the contract of the Medical Examiner must be not be in the Medical Examiner must be not provided to the contract of the medical Examiner must be not provided to the contract of USA 21211 830 WEST 40th STREET death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 ☐ No Specify: laltimore, Maryland 21215-0036 þ 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ARCHAEOLOGY PROFESSOR 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be PAULINE OHLE FREDERICK MATSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANNE D. HOPKINS daughter 45 WARRENTON ROAD BALTIMORE, MARYLAND 21210 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 3/29/2007 BALTIMORE, MD. GREENMOUNT 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD. MONKTON, MARYLAND 21111 NACI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day for in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 ∐Nnknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably retention page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🖼 No 1∏ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
Sompletely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MAYEH Name and address of person who completed cause of death (Item 23a) (Type, Print) CHarles Street Baltimori Mar 5901 north AY 2. Registrar's Signature 31. Date filed (Month, Day,

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28 MARCH 2007 5:25a M THOMAS MASON METZ 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE PARKVILLE MORNINGSIDE HOUSE 8. Date of Birth (Month, Day, Year) 02/02/1912 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Months Days Hours Min. VIRGINIA 1**♥**M 2□ F Yrs. 95 577-24-3317 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No PARKVILLE MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 8800 OLD HARFORD RD 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ARTIST ARTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS ALONZA METZ NANNIE M. LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHESAPEAKE AVE TOWSON, MD. 21204. KIM McGAVIN (ATTORNEY) 305 WEST 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 03/30/2007 | PIKESVILLE, MD. DRUID RIDGE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Maneral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO 16924 YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sudden Myocardial infarction Due to (or as a consequence of) years Coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease 1 Tes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

attending physician and for use as the burial-transit

Completed by

Be

2

Certification:

Medical

State Registrar

Department of Health ar Important: If Item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

show

Director

Be Completed by

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Mason Metz

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be innent of Health and Mental

Examiner Physician/Medical

Perpheral vascular disease

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one) 28c. Injury at Work?

Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

performed 1∐ Yes

2X No

24a. Was an

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie. 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)

D30433

29c. License number

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

March 29, 2007

Mel Daly MD GBMC 6701 North Charles St. Baltimore, MD 21204 31. Date filed (Month, Day, Year)

MAR 2 9 2007

DHMH 17 Rev 1/2001

within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Division or Vital Records, P.O.

25. Was case referred to medical examiner 1 ☐ Yes 215 No

27. Manner of Death 1 X Natural 2 Accident

3 ☐ Suicide

(Check only one)

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

and manner stated.

28h Time of

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Aichael Edwa	ard I	1. For State	nent o	or Health a	re All C	opies	Are L	egible		7 7 700
Phys	icia	Registrar Certific	cate o	f Death				Reg No.	201	07 099
Medical Exa	min	ar Michael Edward McClure 4a. Facility Name (if not institution, give street and number)					Date of De Month March 20	eath Dav	Year	3 Time of Death 0326 hrs
		Park and Ride off Route 100		4b. City, Town, of Ellicott City		f Death			County of E	Death
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday)	If Under 1 Ye		r 24Hrs 8	R Date of F	- 1	oward	8 Birthplace (State or
Direct	or	219-19-0952 1XM 2F 34	Yrs	Months Da		Min.	March		iF(oreign
ģ		Usual Residence of Decedent 10a. State 10b. County					March	31 .	19/2	Country)Marylan
br work	ان	Toc. City, Town								10d. Inside City Limit
farylar 8a-fs	illied at onc	MD Howard Elli 10e Street and Number	icott	City 10f. Zip Code						1 XYes 2 N
ith the Maryland	i c			Tot. Zip Code	21043			10g. Citize	of What (Country?
th with		11. Marital Status 12. Was Decedent Ever in U.S.	13, Wa	s Decedent of Hi	spanic Origi	n? (Specif	v Yes or N	0- 11	USA	
er dear	1	1 Never Married 2 Married Armed Forces? 1 Yes 2XX No	lf Y	es, specify Cuba	n, Mexican, I	Puerto Rica	an, etc.)		White, et	merican Indian, 81ack, c.
urs aft tural"	1			Yes 2X No				S	pecify: W	Thite
72 ho	Pote	Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent during mo	t's Usual Occupa ost of working life	tion (Give ki . DO NOT u	nd of work se retired)	done	16b. Kin	nd of 8usine	ss/Industry
0036 within 72 iene. eer than *	Comp	12th Ø C	ar S	alesman				7.11	ıtomot	irro
115-1 filed al Hyg ed oth	8				18 Mother's	Name (Fire	st, Middle,			
212 ould be Ments mark	To B	10- 1-6	B.4+10		Sand	lra L.	Hine	es		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmitic event the Madical Promition		Mark E. McClure/Father	412	Address (Stree	et and Numbe	er or Rural	Route Nur	mber, City	or Town, St	
or Heal		20a. Method of Disposition 20b. Place of	T DISPOSIT	Blue Sto	netery,	Dar Dar	COLUI	nbla,	MD cation - City	21046 or Town, State
LimC Page ment tant:		4 Donation 5 Other Specify West	ary or other	del Cren	n.	3/30/	2007		nton,	
Ball permit Depart Impor		21 Signature of Funeral Service Licensee	22. Na			Donal	dson	Fune	ral H	ome, P.A.
Physician		23a. Partil. Enter the disease, or complications that caused the death December 1								707
/Medica	1	Part I Enter the disease, or complications that caused the death. Do not failule. List only one cause on each line. Immediate Cause (Final disease a. Asphyxia	enter the	e mode of dying,	such as card	liac or resp	piratory arre	est, shock,	or heart	Approximate Interval 8etween Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) Asphyxia Due to (or as a consequence of):								Death
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated (Disease or injury that initiated								
recuted and - transit		events resulting in death) Last Due to (or as a consequence of):								
execu ian and ial - tra	cian/Medical	d. UNPENDED AMENDED								
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Box 68760 e death certificate be the attending physical	ian/	past 12 months?	Fetal	death 3	Ectopic pre	egnancy		23d. Da Mor	ate of delive	ry Day Year
Box ie death the atte	Physic	1 Yes 2 No 9 Unknown 9 Unknown	Othe	r (Specify)				Ť		,
P.O.	by Pt	Part II. Other significant conditions contributing to death but not resulting in	n the unc	derlying cause give	ren in Part I.	2	3e. Did tob	pacco use	contribute to	the cause of death?
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ord aw rec as bee	Completed					2	4a. Was ar		4b. Were a	utopsy findings available
Rec The I	Son					_	perform Yes 2	ned?	death?	completion of cause of
ital sician: s certii rector	a	25. Was case referred to medical examiner? Hospital: Inpution: 2 EP/Outs			f Death (Che				1 🗸 Y	es 2 No
Division of Vital Records, P.C tal or Attending Physician: The law requires that its after death al Director: After this certificate has been signed led in by the funeral director, page 2 should be dete	£	27 Manage of David	atient 3			rsing Hom			6 🗸 Othe	r: Scene
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ivision or Attendafter death Director:	ifica	2		1						
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To the Ho within 24 P To the Fur completely	ical	29a. Certifier (Check only Check only 2 Medical Examiner: On the best of my knowledge, death one)	occurred	at the time, date	and place, a	and due to	the second	-1 - 1		
To the within 7 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or inveand manner stated 29b. Signature and title of certifier.	stigation,	, in my opinion, d	eath occurre	ed at the tin	ne, date an	id place, ai	nd due to th	e cause(s)
6		XICIAIXNI		29c. License r			- 1			nth, Day, Year)
6		30. Name and address of person who completed cause of death (Item 23a)		O.C.M.	c.			March 2	6, 2007	
5		Susan Hogan MD. Assistant Medical Examiner 111	Penn S	Street, Baltim	ore, MD 2	21201				
0.4	78	31. Date filed (Month, Day Year)		, ==:::::						

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month 3:30 p. M Warren F. Marr 2007 /Medical March 24, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON
If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Gilchrist Center Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs. Director 76 Aug. 2, 1930 178-22-5111 Usual Residence of Decedent Pennsylvania the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2X No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? p e items 23a oner must b 1712 Melbourne Road 21222 by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Examiner 1 XYes 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than ' Elementary/Secondary (0-12) College (1-4or 5+) Clerical 12 years Accounting Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked ၉ Charles J. Marr Sallie Beeler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Charles Marr (Son) 8196 Gumtree Drive Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If its any Injury or o XIX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 3/28/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 0 2h 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUDDURAL Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leauning to minimum at cause. Enter Underlying Cause (Disease or injury Examiner Due to (or se's consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Metastratic Drostate cancel 1 Yes 2 No 3 Probably 4 Unknown Completed Thrombocytopenia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s eft les allep vein thombases 1□ Yes 25. Was case refered to medical examiner? Be 26. Place of Death (Check only one) examiner? 1X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE

Injury at Work?

1 Yes 2 No Next to bed rolled out Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 5 Pending investigation early AM 2 Accident
3 Suicide 11/2007 286. Place of injury · At home, farm, street, factory, office building, etc. (Specify)

Attace - to ER 3/13/07 hip rain 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1712 mcl bounce Rd pletely filled in by 4 Homicide Hospital to the Funeral 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) allle 25643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Faulliner MD/555 W. Tousantown Blud/Bacto MD 21204 32 eg rar's Signature 31. Date filed (Month. State Registrar

DHMH 17 Rev 1/2001

:30PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			State of Marylar	'	partment of F e <i>rtificate of</i>			20	07 0	9966
			Decedent's Name (First, Middle, Last) A			Death	2. Date of Dea	Reg. No 🛴 🔱	3. T	ime of Death
	Physici		FETHER M.	AR	R		Month	Day 18	Year 11	PM
And the same	/Medio Examir		4a. Facility Name (If not institution, give street and number)	•		4b. City, Town, or Lo				
	LXamii	161	ROCK GLENN NURSI	NG	CENTE	2 BAL	TIMO	RE		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		1 11 11 11 11 11	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		9. Birthplace (5 Country)	state or Foreign
	Director		577-48-5590 ^{1□M 2} ∑F 71	Yrs.	MOTILIS Days	Hours Will.	Dec 9,	1935	Virginia	
	Pu .		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or	Location				10d Inc	ido City Limito
	shor	7		11ege						ide City Limits Yes 2√ No
	28a-f	ectc	10e. Street and Number	rrege				10a Chinan at l		-X
	with a s	Funeral Director	4711 Berwyn House Road		10f. Zip Code	7.4.0		10g. Citizen of '		
	eath rs 23	eral	11. Marital Status 12. Was Decedent Ever in U.	S 13		740 Iispanic Origin? (Spe	cify Yes or No-	US.	A ce - American Indi	an.
	ter d	Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	,0.	 Was Decedent of H If Yes, specify Cuba 	an, Mexican, Puerto I	Rican, etc.)	Bla	ck, White, etc.	M11,
720	irs el	by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify	white	
5-0020	filed within 72 hours efter death with the Maryland Hygiene. thy then "natural", or terms 23a or 28s-f show int, the Medical Examiner must be notified at	ted	15. Decedent's Education	16a. Dec	edent's Usual Occup	ation	1	16b. Kind of B	usiness/Industry	
7	thin 7	Completed	(Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+)	life	edent's Usual Occup re kind of work done o DO NOT use retired	during most of workii d)	ng			
7	filed wi Hygien ther th	Con	12 0	W	aitress			restar	aunt	
and	ld be filk ental Hy ked oth Ic eveni	Be	17. Father's Name (First, Middle, Last)		unk	18. Mother's Name	(First, Middle,	Maiden Suman	ne)	
Z	Men Men arke	ို				Rosa Ann				
	l sho		19a. Informant's Name/Relationship <i>(Type, Print)</i> Michael Wilson/son		iling Address <i>(Str</i> eet) 9 S. Hanov					
e,	s 1 end 2 sh f Health end Item 27 Is n other traun		-	1			Date		D 21230 City or Town, Sta	
0	9 5 = 9		I Burial 2 Cremation 3 Hemoval from State	emetery, cr	positio n (Name of remetory or other place	e)	Date	200. Location -	City of Town, St	ile.
_	E E E		4 🗓 Donation 5 🗆 Other (Specify)		OO blooms and Address	and Facility				
מ	permit. Departm Importa eny Inju		21. Signature of Funeral Service Licensee Ronald S. Wade Director	ר וי	State Ana			. Balti	more Str	eet
			Sem /// Cull		Baltimore	•				
			23a. Part1 Enter the disease or complications that caused the death shock or heart failure. List only one ceuse on each line.	n. Do not e	nter the mode of dyin	g, such as cardiac of	r respiratory arr	est,	Interva	ximate al Between and Death
	Physician /Medical		Immediate Cause (Final		P				000	
	Examiner		disease or condition resulting in death)	na	at 1	14ng			1	
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	outed ensit	Examiner	Sequentially list conditions Due to (o)	r es a cons	equence of):	Lung	41.	200		
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	e dee	Sici	Part II. Other significant conditions contributing to death but not resu	ulting in the	underlying cause give	en in Part I.	23b. Did to	becco use co	ntribute to the ca	use of death?
	d by t	된	Atrial Fibrills	stich			10 Y	es 2 No	3 🗌 Probably	4 🗌 Unknown
ה מ	signe d be d	و ک	7770100						Data Mana auto	as. tip dines
5	nedni houk	Completed					24a. Was a perfori	n autopsy ned?	24b. Were auto available p	prior to n of cause
ַנֻ .	has b	현							of death?	
- 6	cate						1 □ Ye	es 2 No	1 ☐ Yes	2 NO
	certifi	Be	25. Was case referred to medical examiner? Hospital:		Othe	26. Place of Death				
5	this ral di	<u>د</u>	1 ☐ Yes 2 ② No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ER/Outpation 28b. Time	ent 3LI DOA	4 I Nursing Hom		ence 6 DOth		
5	After	盲	1 ဩNatural 5 ☐ Pending (Month, Day Yeer) 2 ☐ Accident investigation	Injury	Work	(? Yes 2 □ No		,,	-	
2	Atten r deel	E	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho	me, farm, s	treet, factory, office	2			er or Rural Route	Num ber,
	efter Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify	1)			City or Town	n, State)		
	ospita hours uners ily fille		29a. Certifier 1 Certifying Physician: To the best of my know	vledge, dea	th occurred et the tim	e, date and place, er	nd due to the ca	ause(s) and ma	nner es stated.	una(a)
1	To the nospiral or Attending Physician: The law requires thet the deeth cert within 24 burs efter deeth. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be deteched for use a	edical	one) and manner stated.	ion and/of l						
	Neith Con	Σ	29b. Signature and title of certifier	Mn	29c, License	number		4	d (Month, Day, Ye	
ı			> Amoun M Macem 1		$\mathcal{L}\mathcal{L}\mathcal{L}\mathcal{L}\mathcal{L}\mathcal{L}\mathcal{L}\mathcal{L}\mathcal{L}\mathcal{L}$	5503	//	1910h	212	001
			30. Name and address of person who completed cause of death (Item	23e) (Type	Print)	his st	Bolt	mo	2/2	12
	Stat	0	31. Date filed (Month, Day, Year) 32. Registrar's Signat	uraa	Duly	, 0,	1110	1110)	W/W/	
	Otal	9	1185 0 0 2007 Par	A.	- AND TO					

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			For State Registrar	State o	f Maryland		artmen			and M		jiene	2007	0996	
	Physici /Medio		1. Decedent's Name (First, Middle Harry	B. M	yers						2. Date of Dea Month	26 Day	2007	3. Time of Death 2:00PM	
)	Examir Funeral Director	ier	4a. Facility Name (If not institution 2 15 Sull 5. Social Security Number 227-22-8671	ivan Ro	neer) Occ C 7. Age (In yrs. last 79	birthday) Yrs.	4b. City, If Under Months	rest	Location of United Hours	ster	8. Date of Birth (Month, Day Apr 14,	Car	unty of Death 1011 9. Birthp Count Virgi	lace (State or Foreign try) .nia	
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic avent, Ita Medical Exaction and the notified at QDCs.	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Carro		10c. City, T		cation nster							0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
			10e. Street and Number 215 Sullivan Road				101. Zip Code 21157					0g. Citizen of What Country? USA			
		þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:					o- 14. Race - American Indian, Black, White, etc. Specify: White			
		To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 10 15. Decedent's Education (Give kind of weight in the properties of the proper					of work done during most of working OT use retired)					6b. Kind of Business/Industry plumbing		
										e (First, Middle, Maiden Sumame) ie McDaniel					
			19a. Informant's Name/Relationship (Type, Print) Kathleen Frazier/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9400 Orbitan Court Baltimore, MD 21234												
			20a. Method of Disposition 1 Burial 2 Cremation 4 XDonation 5 Other (S	Specify)	State 20b. Place ceme	etery, cren	natory or o	ther place			ate		on - City or To		
Bal			21. Signatur of Funeral Service Licensee Ponald S. Wade Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attanding Physician: The law requires thet the death certificate be executed The law within 24 hours shield reduce the set of the stending physician end To the Funeral Director: After this certificate has been signed by the ettending physician end To the Funeral Director: After this certificate has been signed by the ettending physician end Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To picture the standard physician end To picture the standard physician end To picture the standard physician end To picture the standard physician end The standard physicia	Medical Certification; To Be Completed by Physician/Medical Examiner	shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown									23d. Date of delivery Month Day Year			
													ne cause of death?		
			25. Was case referred to medica				- i alignone		26 Place	of Death	24a. Was a autops perform 1 Yes	ned? No	4b. Were autoprior to condeath? 1 Yes	psy findings available impletion of cause of	
			examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing 27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 28b. Time of Injury Work?								Home 5 Residence 6 Other (Specify) 28d. Øescribe how injury occurred				
			1 Natural 5 Pendir investi 3 Suicide 4 Homicide	not be 28e. Place	(Month, Day Year) Injury 28e. Place of Injury - At home, farm, stre building, etc. (Specify)			M 1 Yes 2 No			28f. Location (Street and Number or Rural Route Ni City or Town, State)			l Route Number,	
			26a Cartier (Check only one) Certifying Physician: To the best of my knowledge death oncurred at the time, date and clade, and due to the cause(s) and marker as stated and marker as stated (and in the cause(s) and marker as stated (and in the cause(s) and marker as stated (and in the cause(s) and marker as stated (and in the cause(s) and marker as stated (and in the cause(s) and marker as stated (and in the cause(s) and marker as stated (and in the cause(s) and marker as stated (and in the cause(s) and due to the cause(s) and d												
			29b. Signature and tiple of sentities				29c. License number				. 2	29d. Date signed (Month, Day, Year)			
			30. Name and address of person the completed cause of death (Item 23a) (Type, Print) Charles M. Harrison MN 3900 Lockkaven Blud. Baltimol MD 21218											21218	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9	32. R	egistrar's Signature		2062 1			0		, - t y u	-,,		

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12:35 PM DINE James Mary 2007 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** yview Medial Johns Hapkins 5. Social Security Number Battimore Center If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 ☑ M 2 □ F 426-82-0293 63 Apr 24, Director 1943 Mississippi Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Funeral Director MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3927 E. Lombard Street #6 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 painter home improvements 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cleon Mcalpine Edna Streeter ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Daniels/sister 504 N. Bayou Cleveland, MS 38732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state 21. Signatur of Funeral Survice Licensee Ronal d S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Physician ardial ሣነክና /Medical Due to (or as a consequence of) **Examiner** OSis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Necrosia Bowel Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria filallation Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at a be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an certificate has birector, page 2 s autopsy performed? res 2 1 fo the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Medical Certification: To 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) MAR 2 9

Jeffre.

29b. Signature and the of certifier

4940 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pelver

08462

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician March 26° 2007 6:55 рм McAdam Norma R. /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Towson 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month Day, Year) March 14, 9. Birthplace (State or Foreign 1930 Country) Ohio If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 X F 214-26-8720 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 1 ☐ Yes 2X No Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified once. Baltimore Towson Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6806 N. Charles St. 21204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 White Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Frischer Frank P. Ragonese ပို 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11715 Janney Court Clarksville, Md. 21029 Margaret Ondov/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 3-30-07 Hilltop Service Co. Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility uneral H RUSK YORK Rd. Towson, 21. Signature of Funegal Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SHLOKE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔲 Yes 2 No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) NOS PLCE 1 ☐ Yes No Mo 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Injury 12 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral [🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) rentes ST TOWSON, MO ZNOZ AMON ver, NO 6701

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 9:00 P Dorcas McCormick March 12 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Jan 31, 1909 Raeford, N.C. 1 □ M 2 👿 F 98 579-14-3039 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County induture necessary Hygiene.

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In marked other than "natural", or items 23a or 28a-f show imarked other than "natural", or items 23a or 28a-f show imarked other than "natural Examiner must be notified at 1 XYes 2 No Maryland Prince George's Temple Hills Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20748 3318 27th Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Services Admin Twe1th Four Accountant 18. Mother's Name (First, Middle, Maiden Surname) th and Mental Hy 17. Father's Name (First, Middle, Last) Be Julia McBryde John E. Graham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3318 27th Avenue, Temple Hills MD 20748 Veronica Newton/Daughter Health Health mit. Pages 1 and partment of Health cortant: If Item 27 injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) March 19, permit. Page Department of Important: If any injury or Lincoln Cemetery 2007 Brentwood, Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signature of Funer I Service Lice 1661 Good Hope Rd SE, Washington DC 20020 Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed attending physician and for use as the burial-tran consequence of Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specity) After this certificate has been signed by the a funeral director, page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Minpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 27. Manger of Death Injury at Work? 1 Natural 5 Pending M 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 Old Branch Avenue #101, Clinton, Maryland 20735 Laxmi Berwa 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend #10g Per FH G865 3/29 Opportment of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZO AM Year **Physician** NEWELL ORINNE ASTR. 03 2007 26 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ADVENTIST HOPITAL TAILOMA PARK MONTGOMERY WHEHENGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 8. Date of Birth Month, Day, **Funeral** Days Min. 1□M 2**X**F Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hyglene. 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MARYLAND PRINCE GEORGES HVATTSVILL 10g. Citizen of What Country? 10e. Street and Number Bermuda 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 College (1-4or 5+) Elementary/Secondary (0-12) HEALTH CARE CENTER 5515TAN7 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental h and Mental 7 Is marked o EVAUAX ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BROWN of Health 605 FAST LIGHT DR, SILVER SPRINGS, MD, 20903

Of Disposition (Name of 20c. Location - City or Town, State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 permit. Pages
Department of
Important: If It
any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State SOMERSET, BERMUDA 4 ☐ Conation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee JR, FUNERAL HOME 10 75N:1 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death HEART DISEASE ARTERIOSCLEROTIC Physician se or condition ting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
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| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO055918 26/2007 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON ADVENTIST HOSTITAL mD ROSS SWITHES 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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N. C. C. C. C. C. C. C. C. C. C. C. C. C.	4a Facility Name (if not institution, give street and number) 5211 Paint Branch Pkwy	4b. City, Town, or Location of Death College Park	4c. County of Death Prince George's
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	4 Homicide 29a Certifyer 1 Certifying Physician: To the best of my knowledge, declared to the control of the c	eath occurred at the time, date and place, and due to the ca	nuse(s) and manner as stated.
To the He within 24 To the Fu Completel	and manner stated.	investigation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
≥	29b Signature and title of certifier My My D	O.C.M.E.	March 27, 2007
16	30. Name and address of person who completed cause of death (Item 23a)		
10	Ling Li, MD Assistant Medical Examiner 111 Per		
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Cooks	

DHMH 17 Rev 1/2001

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building, etc. (appearly) 29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	9	ng ph		IE EEMALE:								1	
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wend: Klocsz Getal North Pay, Year) State Registrar 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/25/07 31. Date filed (Month, Day, Year) 32 Registrar's Signature	á	s efte	Cert	4 Homicide	bui	iding, etc. (2	преспу)			Chy or 70	- State)		
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Wand Klong mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wand: Klocsz 6701 N Charles St Suite 4702 Towsm Md 21204 State Registrar 31. Date filed (Month, pay, Year) 2007 32 Registrar's Signature		To th To th compl	Me	29b. Signature and title of certifi	er			29c. Licens	se number		29d. Date signed	(Month,	Day, Year)
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State 31. Date filed (Month, Day, Year) 2007 32 Registrar's Signature		12		30. Name and address of perso	who completed ca	use of death	(Item 23a) (Type	Print) Suite 40	02 Tou	-sor m	12 2120	4	
W T				31. Date filed (Month, Day, Yea	9 2007 2	Registrar's	Signature	raile					

			Please	Type or Prin	t in B	llack	Indelible	e Ink.	Ensure A	II Copies	s Are	Legible.	
		For		State of Ma	arylan		•			Mental Hy	/giene	е	
		1 - State Registrar				C	Pertificat	e of	Death		Reg. No	2007	09974
Physicia	an	Decedent's Name	e (First, Middle, L.							2. Date of D Month	Da		3. Time of Death
/Medic				Drummo	ond C	rr	41.03			March			9:55 A [™]
Examin	er	,		ve street and number)					r Location of Death			c. County of Dea	
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Director		212-24-0	435	1X M 2□F 7	9	Yrs	Months	Days	Hours Min.	Oct 1!			ountry) cyland
pu ,		Usual Residence of 10a. State			10c City	, Town o	r Location						10d. Inside City Limits
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the M 28a-f notifie	ect	MD 10e. Street and Nu	Prince	George	Gre	eenbe	10f. Zip	Code			10a. Ci	itizen of What C	ountry?
with 3a or 1 be r	D									U.S			
death ms 2: · mus	Funeral Director	11. Marital Status	IIIIIII RO	12. Was Decedent B	Ever in U.	S.			lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N		14. Race - Am	
after or Ite mine	F.	1 Never Marr	ned 2 Married	Armed Forces? 1 ⊠ Yes 2 □ N If Yes, Give	10		1 ☐ Yes		Specify:	o nican, etc.)		Black, Wh	ite, etc.
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י 72 ה "natı edica	lete	(Spec	15. Decedent's E cify only highest g	ducation ade completed)		16a. Do	ecedent's Usu Give kind of wo fe. DO NOT u	al Occup ork done se retire	ation during most of wor d)	king	16b. F	Kind of Business	s/Industry
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medikal Examiner must be notified at	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5 4	+)		cher	00 / 011/ 01	-)		Pu	blic Sc	hools
i filed I Hyg other	Be C	17. Father's Name	(First, Middle, Las	t)					18. Mother's Nam	ne (First, Middl			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To B	William	Eaton Or	r					Jenny Sr	pears			
2 sho and l		19a. Informant's N	ame/Relationship	(Type. Print)		19b. N	lailing Address	(Street	and Number or Ru	ral Route Num	ber, City	or Town, State,	Zip Code)
and lealth m 27			Orr /sp	ouse	20h D				Road, Gr	reenbel Date	, ,	aryland -ocation - City o	
ages in of h			☐Cremation 3 l	☐Removal from State			isposition (Na crematory or		1				
iit. Partmei			5 Other (Spec		Lau	ıreı	22. Name a	nd Addre	ery Apr			SCOW Mil	.ls, MD
Department Department	22. Name and Address of Facility Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 2070											0707-4200	
4 4		23a. Part1. Enter	the dispase, or cor	nplications that caused	the death							ylanu Z	Approximate Interval Between
Physician		Immediate Cause	(Final	y'one cause on each lir GI Blee									Onset and Death
/Medical	resulting in death) a. Due to (or as a consequence of):												
Examiner		Sequentially list co	onditions.	_{b.} Gastric									6 months
ed sit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying	Due to (or as	a consequ	uence of)							
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The law requires that the death certificate be ate has been signed by the attending physicial bage 2 should be detached for use as the bur	Physician/Medica												
th cer endin r use	an/N	IF FEMALE: 23b. Was deceden		23c. If yes, outcome 1 ☐ Live birth			3 □Ectopic p	regnanc	v			23d. Date of de	
e dea he att	sicia	in the past 12 1 ☐ Yes 2 I	□No	4□Pregnant at 9□Unknown			5 ☐ Other (s					Month	Day Year
w requires that the d been signed by the should be detached	Phy	9 Unknown		contributing to death be	ut not resu	ulting in th	ne underlying	rause niv	ven in Part I	23e Did	tohacco	use contribute	to the cause of death?
signe d be c	l by	Stroke	mount oonaniono	contributing to doubt 2		annig iir u	.o undonying	auoo g					Probably 4 ☐Unknown
v requ	Completed				-					24a. Wa	san	24h Were :	autopsy findings available
slcian: The faw s certificate has t irector, page 2 s	du									aut per	opsy formed?	prior to death?	completion of cause of
		25. Was case refe	rred to medical						26. Place of Dea	1 Yes	- 1	lo 1 □Ye	s 2 No
Physici r this cer ral direc	To Be	examiner? 1 ☐ Yes 2 🔀	No	Hospital: 1X Inpatie	ent 2 🗌	ER/Outpa	atient 3 □ D	OA Oth	er.			6 ☐Other (Sp	ecify)
Attending Physician: r death. ector: After this certificaby the funeral director,	28b. Time of leath 28a. Date of Injury 28b. Time of leath 28c. Injury at 28d. Describe how injury occurred 28d. Describe how inj												
tendl eath. tor: A the fu													
l or Attend after death Director:	rtifi	4 ☐ Homicide	determine		ury - At no c. <i>(Specif</i>)	me, tarm	, street, factor	у, опсе			(Street a own, Sta		Rural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier		hysician: To the best									
he Ho in 24 I he Fu	Medical	(Check only one)	2 Medical Exa	aminer: On the basis of and manner sta		tion and/				irred at the time	e, date ai	nd place, and du	ue to the cause(s)
Vaith Com	Σ	29b. Signature and		~ ~		11.			se number	(0)		ate signed (Mor	
1) -/		13	Mea	m. Di	ou	ng		40	00 5931	V	Ма	arch 28,	2007
TU			ress of person wh Neckritz,	completed cause of d				-i 17^	Cuita 2	22 Fa-	uro 1	MD 205	707
Sta	ite	31. Date filed (Mor	nth, Day, Year)	3 Registra	ar's Signa	ture	ark DI	. I ve	, Suite 2	2), Lal	itel,	MU ZU	0 /
Registr		N	MAR 2 9 2	Registr	, 1	B	sauce?						

Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Honeral Director. After this certificate has been signed by the attending physician and programment in the formation of the form	ner
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Render in by the fundation of the following the following the following the following the following the fundation is by the fundation of the fundation o	delipietely illied in by the faring
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			For State		State o	f Marylar		artment of rtificate o			-	giene Reg. No.	2007	09975
			Registrar 1. Decedent's Name (First,		,			imouto c	Doan		2. Date of De	ath		3. Time of Death
	Physici /Medic		Rosali		0ster						March		200 7 ear	1:40 рм
	Examin	er	4a. Facility Name (If not ins Blakehurs	_	street and nu	mber)		4b. City, Town		of Death			County of Death	
	Funeral Director		5. Social Security Number 216-46-1624	6. S	ex □M 2 ⊠ F	last birthday) Yrs.	If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Bir July 2	th Year	908 ^{9. Birth}	place (State or Foreign	
	and ww		Usual Residence of Deced 10a. State 10b. 0	ent County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Maryl a-f sho ified a	tor	Md. Ba	ltimo	re	To	owson							1 □Yes 2 No
	th with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 1055 W.	Jopp	a Rd.			10f. Zip Cod 21204				10g. Citi	izen of What Cou USA	intry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2[3 ☑ Widowed 4 □ Di	_	Armed Fo	2 No ve	1	Was Decedent of Yes, specify C			ecify Yes <i>o</i> r No Rican, etc.))-	14. Race - Amer Black, White Specify: Whi	, etc.
Maryland 21215-0036	within 72 ho ene. than "natur e Medical	Completed	15. De (Specify only Elementary/Secondary (ucation de completed) College (1-4or 5+) +4	(Give	dent's Usual Ockind of work do DO NOT use rei Memaker	ne during mo tired)	st of worki	ing		ind of Business/li n Home	ndustry
land 2	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Mec	To Be Co	17. Father's Name (First, Milliam S						18. Moth		e V. Ha		Surname)	
	1 and 2 shou Health and M tem 27 Is mar other traumat	-	19a. Informant's Name/Re				901 S	outh Bo	nd St.			-	or Town, State, Zi nore, Md	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr		20a. Method of Disposition 1 □ Burial 2 🛣 Crem 4 □ Donation 5 □ O	nation 3 🗆		State	lltop S	sition (Name of natory or other ervice	Co.	3 - 29-		То	wson, Mo	
Balt	permit. Departimport any inj		21. Signature of Junegal Service Licensee 22. Name and Address of Facility Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204											
	Physician /Medical		23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	alse, or comp e. List <i>o</i> nly	one cause on e	caused the dealeach line. Crud (or as a consec	ned.	A 1 a			Pisa		_	Approximate Interval Between Onset and Death
	Examiner ud	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	4	c	(or as a consec	•							
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last		Due to	(or as a consec	quence of):							
.O. Box 6	attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 🗆 Live I	tcome pf pregn birth 2 □ Fet nant at time of o	al death 3 [Ectopic pregna Other (specify					23d. Date of deliv	very Day Year
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or Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to rexaminer?	nedical	Hospital:	2511			26. Plac	e of Death	(Check only o	one)		-
or	ing Phys After this (funeral dir	1: To	1 ☐ Yes 2 ☐ No 27. Mapner of Death	1	28a. Date	of Injury	ER/Outpatier 28b. Time o	t 3 DOA	njury at Vork?		me 5 Resi		6 ☐Other (Spec ry occurred	ify)
Division	Attencr death	Certification:	2 ☐ Accident	Pending investigation Could not be determined	28e. Place	of injury - At h	ome, farm, str		Yes 2		28f. Location (. City or To	Street an wn, State	nd Number or Rui	ral Route Number,
Ω	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce			niner: On the b) and manner as d place, and due	
	To the	Me	29b. Signature and title of	certifier CeW	uns	MD		D	ense number 334.	00		N2	te signed (Month	007
f	5		IRedel h	/ Ig	Charl	se of death (Iter	0 /2	Print) O/ N	Charle	es Si	treet 1	Bati	timore	WD ZIZIZ
	Sta Registr		31. Date filed (Month, Day,	Year) 0	7007	egistrar's Sign	ature	barte						
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07-02342 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert H. Peach, Jr. State of Maryland / Department of Health and Mental Hygiene 2007 0997 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1740 hrs Medical Examiner Robert Howard Peach, Jr. March 26, 2007 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Peninsula Regional Medical Center Salisbury Wicomico 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Hours 215-40-9506 Davs Director Country) MD 64 1 M 2 F 1942 Oct. 7, Usual Residence of Decedent IOc. City, Town or Location 10d Inside City Limits 10a. State 10b. County MD 1 Yes 2 X No Wicomico s 23a or 28a-f show e notified at once. or 28a-f shov Tyaskin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23049 Capitola Road 21865 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. dother than "natural", or items the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 2 X No Yes 3 Widowed Divorced Yes, Give Year Yes 2 No specify: Specify: White δ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) AD 21215-0036 2 should be filed within 72 ho n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Metal Fabticator Steel Work 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 27 is marked Doris V. Blair tant: If item 27 is marked or other traumatic event, Be Robert Howard Peach, Sr. Pages 1 and 2 should nent of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Barbara A. Peach/Wife 23049 Capitola Road Tyaskin,

20b. Place of Disposition (Name of cemetery, Date MD 21865 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State West Arundel Crematory 3-30-2007 Odenton, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signature of Funeral Sorvice Lice 1328 Sulphur Spring Rd. Arbutus MD 212 Approximate Interval complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease. **Physician** Between Onset and (Maidical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial - transit sician/Medical AMENDED UNPENDED Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ ے 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, page 2 should 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: director, of Vital Be Other₄ Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 🗸 Yes funeral 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death Mar 26, 2007 Subject driver of vehicle in vehicular accident Natural 1 Yes 2 V No Division 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) Whitehaven Rd. & Capitola Rd., Quantico, MD determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within ? and manner stated 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) March 27, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (frem 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD.

State Registrar 31. Date filed (Month, Day, Year) MAR 2 9 2007

,32. Registrar's gnatur

			State of Marylar		artment of Hea stificate of De			000	
		JE1	Registrar 1. Decedent's Name (First, Middle, Last)		A /	zatii	2. Date of Death		3. Time of Death
	Physici /Medic		Sallie		PAHI	110	MARCH	22, ZOO	7 12:23 pm
	Examin		4a. Facility Name (# not institution, give street and number)	.) ,	4b. City, Town, or Lo	cation of Death		4c. County of D	eath
	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	9.1	Birthplace (State or Foreign
	Funeral Director		182-66-7839 ^{1□M 2} MF 2	1 Yrs.	Months Days F	Hours Min.	(Month, Day, 2-1-1	rear)	Country) PA
- June	3		Usual Residence of Decedent 10a. State 10b. County Unk 10c. Cit	ity, Town or Loc	cation				10d. Inside City Limits
Mary	f sho	tor	on the	rham					unk _{□Yes 2□No}
d d	or 28a	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
71215-0036 within 72 hours after death with the Maryland	s 23a o	ral	506 N. Maple		27703			USA	
de de	items iner m	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes ②☑ No		Vas Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
5-0036	ral", or Exam	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	∐Yes 2DXNo S	Specify:		Specify:	Black
2 2 2 2 2	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupatio kind of work done duri DO NOT use retired)	n ing most of work	ing 1	6b. Kind of Busine	ss/Industry
Z idiy	than the Me	ошо	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade NA	ille. L	Retail			Sam's Cl	Lub
De filed	other other vent, i	Be C	17. Father's Name (First, Middle, Last)				e (First, Middle, M	aiden Surname)	
yland yld he filk	Mental Hygiene narked other tha natic event, the	To	Barton Pattillo			Sondra			
Mar	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Barton Patillo-Father	19b. Mailing 7528	g Address (Street and B Penn Av	Number or Run Penue F	a <i>l Route Number,</i> Pittsbur	City or Town, State	15208
baitimore,	of He if item or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State		natory or other place)	1		0c. Location - City	
	rtment rtant: njury c		4 Donation 5 Other (Specify)		urgh Crem	, 0 00	-2007	Vestviev	W, PA
Ba	Depar Impor any Ir once,		21. Signature of Funeral Service Licensee	Jr 22	Name and Address o		arch F/	н East e Balto	, MD 21202
	*	П	23a. Parl 1. Enter the disease, or complications that caused the deal shock, or hearf failure. List only one cause on each line.	tb Do not ente					Approximate Interval Between
PI	hysician		Immediate Cause (Final	mac					Onset and Death
	Medical xaminer		Due to (or as a consec	quence of):					
7	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):					
oo / oo,	physician and the burial-transit	xar	Cause (Disease or injury that initiated events resulting in death) Last C. — Due to (or as a consec	quence of):					
S/OU,	ysiclar re buri	dical							
		Medi	IF FEMALE:						
. BOX C	has been signed by the attending le 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	al death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
2	by the	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	Jedii 5	Other (apacity)				
ords, P.O	gned t	by P	Part II. Other significant conditions contributing to death but not res	sulting in the un	nderlying cause given i	n Part I.	23e. Did toba		e to the cause of death?
COLOS	een si	ted	anoxic eneghalogally				1 Tes	s 2 1.14 76 3 □	Probably 4 Unknown
The law	has b	Completed					24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of
	29 —		25. Was case referred to medical		26	S Place of Deatl		□No 1□Y	res 2□No
40	nis cer direct	To Be	examiner? 1 Yes 2 Hospital: 14 Inpatient 2] ER/Outpatient	Other:			nce 6 Dother (S	Specify)
On Or	h. : After this certific : funeral director,		27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?	2 □ No	28d. Describe how	v injury occurred	
IVISION or Attending	fter deal	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At h building, etc. (Speci		eet, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
J C	within 24 hours after death. To the Funeral Director: Affer completely filled in by the funer		29a. Certifier (Check only 2 Medical Examiner: On the basis of examinary)	owledge, death	occurred at the time,	date and place,	and due to the ca	use(s) and manne	r as stated.
the H	ithin 24 o the F smplets	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License nu			d. Date signed (M	
ř	3 F S		207 200				1.0	1	61 00110
E	'		30. Name and address of person who completed cause of death (Iter	m 23a) (Type, I		1 0	17	MEUI	x , Lou
,)		Matthew Koenig 31. Date filed (Month, Day, Year) 2. Registrar's Sign	O N. I	WOIFE S	t. 154	HIMORE	MARY	And 2128/
	Sta Registr		MAR 2 9 2007	Goes	(L)				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Ragistrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:35 A-M **Physician** RICE 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GENES15 HOMEWOOD BATIMORE CENTOR If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, MAV 19 5. Social Security Number **Funeral** Days 1 X M 2 □ F 19-40-951 MAR Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State or 28e-f show other treumatic svent, the Medical Examiner must be notified at 1XYes 2□No Director og. Citizen of What Country? 10e. Street and Number 82 or Items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Iter any injury or other treumatic svent, the Medical Examinet. once. 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6THGRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 ASHTON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ETRO CREMATORY C 22. Name and Address of Facility 4 Dogation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee BROWN 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or bear failure. List only one cause on each line. ediate Cause (Final Physician METASTATIC LUNG is ase or condition sulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate any process of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ATTENDING 2007 20063335 27 PHYSICIAN HOME WOOD person who completed cause of death (Item 23a) (Type, Print) NANG 00 , MD 31. Date filed (Month Day, Year) MAR 2 9 2007

Registrar DHMH 17 Rev 1/200

State

32. Registrar's Signature

07-02195 John Parker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Parker		State of Maryland / Departmen - For State Certificate	Mental		Reg. No.	200	7 0997		
Physician Medical Examine	1	Decedent's Name (First, Middle, Last)				2. Date of De Month March 22	Day	Year	3. Time of Death 0850 hrs
		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital	1	b. City, Town, or L Baltimore	ocation of Dea			. County of Dea	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs, last birthda	ay) Yrs	If Under 1 Year Months Days	If Under 24th Hours N	1 Feb	irth(MM/	Fore	irthplace (State or ign ountry)
Aaryland 28a-f show any 1 at once.	Ī	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1	Locati	Baltin	nore				10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.		3939 Bolond Aug		10f. Zip Code	11		10g. Citiz	zen of What Co	untry?
iter death wi	Lauerai	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Y	s Decedent of Hispans, specify Cuban, Yes 2 No	Mexican, Pue			14. Race - Ame White, etc.	rican Indian, Black,
5-0036 Howitin 72 hours after the within 72 hours after the state of the result of the Medical Examine for manifested by	Completed b			t's Usual Occupationst of working life. [16b. k	Kind of Business	/Industry
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	8	17. Father's Name (First, Middle, Last) Sohn Par Kev			Beth	me (First, Middle	aile	<u> </u>	
MD 212' nd 2 should be lith and Menta m 27 is marke aumatic event	L	Katherine Parker 30	13	1 /	nd A	ve Ba	140	and	91911
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and M important: If item 27 is n injury or other traumatic		20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		ition (Name of cemoner place)	etery,	Date - Z-07	20c. I	Cocation - City of	r Town, State P(1) MD
		21. Signature of Füheral Service Licensee	11	ame and Address of	32 M	iduallo	10	r Jessi	P) 8A
Physician Medical Examiner	1	23a. Part 1 Enter the disease, or complications that caused the death. Do not entail failure. List only one cause on each line. Imm I ate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			uch as cardia	c or respiratory &	rrest, sho	ock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, ff any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	_				_		
risit red way	Examin	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):							
e be executed skician and burial - transit	allca	UNPENDED AMENDED							
ox 6876 ath certificat attending phy or use as the	Sician/N	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	=	tal death 3 ner (Specify)	Ectopic pres	gnancy	230	d. Date of delive Month	ry Day Year
, P.O. E res that the c signed by the be detached	2	Part II. Other significant conditions contributing to death but not resulting in	the u	inderlying cause giv	ven in Part I.	23e. Did			o the cause of death?
Division of Vital Records, rater death of Physician: The law require rafter death. The Director: After this certificate has been sited in by the funeral director, page 2 should be restricted.	Completed					pen	s an opsy formed? 2 V N	prior to death?	tutopsy findings available completion of cause of
F Vital Rec Physician: The rr this certificate ral director, page	å	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Output	atient		of Death (Che Other Nu	ck only one) sing Home 5	Reside	ence 6 Oth	er:
ion of tending Pheath. or: After the funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time (Month, Day, Year)	ie of I	1	at Work?	28d. Describe	how inju	ury occurred	
Divisi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm (Specify)	, stree	et, factory, office bu	ilding, etc.	28f. Location or Town,		ind Number or F	Rural Route Number, City
To the Hos within 24 hu To the Fun completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inversion and manner stated.							
	Me	29b. Signature and title of certifier Mung Brasse (M)		29c. License O.C.M				Date signed (M ch 22, 2007	
2		30. Name and address of person who completed cause of death (Item 23a)	11 F	enn Street, Ba	altimore, M	ID 21201			
Stat Registra	32	31. Date filed (Month, Day, Year) 22. Registrar's Signature	- 4						

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Month Physician Robert Prager, Sr /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 7. Age (In yrs. last birthday, tonl Gen Burnie If Under 1 Year If Under 24 Hrs. Hrund ecurity Number 6. Sex 8. Date of Birth (Month, Day, May 14, 9. Birthplace (State or Country) Maryland Sex \ 1 X M 2 □ F Months Days Hours 213-28-1687 1932 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Funeral Director Anne Arundel Millersville MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8049 Veterans Highway Lot 64 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 49-53 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No 49-53 Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chemical Industry Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Elizabeth Wooten Joseph Prager 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2144 Vailthorn Rd Middle River, MD 21220 Robert Prager, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory, Inc 3/27/07 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respirably disease or condition resulting in death) (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 1 No Medical Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 M Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

requires that the death certificate be executed as the burial-tran and Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria been signed by should be detac has page 2 certificate director this

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Department of Important: If any injury or once.

Physician

/Medical

Examiner

or Attending Physician: funeral After death. the after death filled in by within 24 hours a

To the Funeral Hospital

6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

(Check only one)

1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 30. Name and address of parton who completed cause of death (Item 23a) (Type, Plint)

29d. Date signed (Month, Day, Year)

State Registrar

completely

31. Date filed (Month, Day, Year) MAR 2 9 2007 32. Registrar's Signature

ola Piccioni		State of Maryland / Department of Certificate of			201	07 09981
Physici ledical Exami		1. Decedent's Name (First, Middle, Last) Lola Piccioni		2. Date of Deat Month March 23,		3. Time of Death 1021 hrs
		4a. Facility Name (if not institution, give street and number) University Hospital	b. City, Town, or Location Baltimore		4c. County of [Death — —
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 579-66-8152 1 M 2XXF 58 Yrs.	If Under 1 Year If Und Months Days Hour		F	B. Birthplace (State or or oreign Washington Country)
i ow any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. Randallst 10c. City, Town or Location 10c. C				10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	10f. Zip Code		ng. Citizen of What	
th the N 23a or		9907 Cervine Lane Apt. 3	21133			es of America
215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. red other than "natural", or items 23a or 28a-f 5he ent, the Medical Examiner must be notified at once	Funeral	1 Never Married 2XX Married Armed Forces? If Yes 2 XX No	Decedent of Hispanic Ories, specify Cuban, Mexican Yes 2 X No specify		14 Race - A White, e	
ours af natural	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	's Usual Occupation (Give st of working life. DO NOT	kind of work done	16b. Kind of 8usin	
MD 21215-0036 d 2 should be filed within 72 h tth and Mental Hygiene. n 27 is marked other than "n mmatic event, th. Medical E.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home M	laker	er's Name (First, Middle, N	Own Ho	те
ore, MD 21215-00 ss I and 2 should be filed wit of Health and Mental Hygien If item 27 is marked other her trammatic event, the M	Be C	17. Father's Name (First, Middle, Last) Melvin Alexander		rtha Price	laiden Sumame)	
212 nould b id Men is marl	To E	19a. Informant's Name/Relationship (Type, Print)				State, Zip Code)21133
_ 2 8 5 2		William P. Piccioni (Spouse) 9907 (20a. Method of Disposition 20b. Place of Disposition	tion (Name of cemetery,	,Apt.3, Kano	20c. Location - Ci	
Baltimore, MD 2121 permit. Pages I and 2 should be in Department of Health and Montal be Important: If rigen 27 is marked injury or other transmatic event.		Burial 2 X Cremation 3 Removal from State Crematory or oth Metro Crem	er place) natory Inc.	3/30/07		e, MD. 21228 Directors, In
Bal permi Depar Impo						aryland 21133
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter th failure. List only one cause on each line. Immediate Cause (Final disease a. Settic shock	e mode of dying, such as	cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
x.	er	Sequentially list conditions, if any, leading to immediate b. Vasculitis with complicate Due to (or as a consequence of):	tions			_
	aminer	C. (Disease or injury that initiated events resulting in death) Last upon to (or as a consequence of):				
executed an and al - transit	ŭ	dd.	<u>-</u>			
be ici	dical	X UNPENDED #Z3a-b,PII,27,perME.g869	, 7/13/07 TT			
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physici page 2 should be detached for use as the buri	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetter		oic pregnancy	23d. Date of de	livery Day Year
Box he death of the death of the attenty the attentihed for us	Phys	1 Yes 2 No 9 ✓ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the un	oderlying cause given in P	Part I 23e Did to	bacco use contribut	te to the cause of death?
r, P.O. B ires that the d signed by the	ð	Morbid obesity, hypertensive cardiovascular d				Probably 4 🗸 Unknown
ords, w require s been si should b	Completed	cirrhosis	LSCASE, IIVEL	24a. Was a		re autopsy findings available r to completion of cause of
Recol The law icate has	ldmc	CHIMODE		perfor	med? dea	
tal Recian: The	BeC	25. Was case referred to medical		(Check only one)		
Vit hysici this c	70 E	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient				Other:
Division of Vital Records, tal or attending Physician: The law requir is after death. The Invector: After this certificate has been seled in by the funeral director, page 2 should the selector.		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of In	1 Yes 2	No	ow injury occurred	D. ID. A. Navibra (th.
트리트	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, stree (Specify)		or Town, St	tate)	or Rural Route Number, City
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	ed at the time, date and pl on, in my opinion, death o	place, and due to the cause accurred at the time, date a	e(s) and manner as and place, and due	to the cause(s)
To To Con	Mec	29b. Signature and title of certifier	29c. License number	r	29d Date signed	(Month, Day, Year)
		Theodor Il to 100 mg	O.C.M.E.		March 27, 20	07
d		30. Name and address of person who completed dause of death (Item 23a)	144 Dam China D	altimate MD 04004		
0		21 Date filed (Marth, Day Voor) 3 Penistrar's Signature		altimore, MD 21201		
S Regis		31. Date filed (Month, Day, Year) MAR 2. 9. 2007				
DHMH 17 Rev 1/2	2001	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 0 11:53 AM 200 RIC hance nauLotte 4c. County of Death 4b. City, Town, or Location of Death 4a. Eacility Name (If not institution, give street and number, OPICINIS tospita Birthplace (State or Foreign Country) 8. Date of Birth (Month Day, Year) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Days Min 1 □ M 2 👿 F 64 18, 1943 579-56-1771 Mar Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2√ No Prince George's Capitol Heights MD10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20743 USA 4311 Torque Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 <u>bookkeeper</u> apartment complex 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lewis James Martha Riggs ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dennis Price/son 4869 Long View Road Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Euneral Service Licensee ROD-Id S. Wage 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street ∠Director 21201 Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andiac ARRhi Dal disease or condition resulting in death) Due to (or as a consequence of) -deara Repra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on. Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Munknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? es 2000 Yes 26. Place of Death Check onl on 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Natural 2 Accident 1 Tyes

Examine death certificate be executed and burial-trai P.O. Box 68760. attending physician for use as the buria Physician/Medical signed by the a or Vital Records. þ should Completed cate has page 2 s certificate Physician: Be P this funeral spital or Attending P nours after death. neral Director: After I After Division

Physician

/Medical

Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

parmit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 and the hybrid in the Medical Examiner must be recons.

Baltimore, Maryland 21215-0036

Director

Funeral

Be

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number KES - 000 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe Street Baltimore, MD 21287 an

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

6 Could not be determined

To the Hospital within 24 hours a To the Funeral I Hospital

			i icase i	State of Mar	vland / Den					•		JIDIC.	
			1 _ State	State of Mai	•	rtificate			id ivie		211	07	09983
			Registrar 1. Decedent's Name (First, Middle, Last))		rimoare	, 0, 0	Can	2	. Date of Dea	eg. No.	7 1	3. Time of Death
П	Physici			CHARDS	ON					Month _	Day -	Year	# 12:08PM
	/Medi Examir		4a. Facility Name (If not institution, give		014	4b. City, 1	Fown, or L	ocation of I	Death		4c. Cour	nty of Death	6
1	LAGITIII		Catonsuille Commons	16 Fustin	na Avenu	e B	alt	imo	re,	MD	Ba	Him	ione County
	Funeral		5. Social Security Number 6. Se	7. Age (in rs. last birthday)	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birth (Month, Day	, Year)	9. Birth	place (State or Foreign intry)
	Director		217-14-3984	JM 2AJF	91 Yrs.					12 0			MD
	and		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation							10d. Inside City Limits
	Maryl f aho	ō	MD NA		Baltin	nore							1 XYes 2 No
	r 28a	rec	10e. Street and Number			10f. Zip	Code			1	0g. Citizen	of What Cou	intry?
	h with	Funeral Director	3820 Woodbine A	ve			2]	1207			U	.S.A	•
	deat deat	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decede	ent of His	panic Origin , Mexican, F	? (Specif	y Yes or No- can, etc.)	14. F	ace - Amer lack, White	
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2		Specify:			Spe	cify: B	lack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow he Medical Examinat nust be inclifted at	q pe	3 XWidowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usua	I Occupat	ion			16b. Kind of		
15	in 72 n "na Audic	Completed	(Specify only highest grad	e completed)	(Give	kind of wor DO NOT us	k done du	iring most o	f working				,
212	filed withi Hygiene. other than	mo	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	Vital	l Sta	tist	ics	Cle	ck S	State	of I	Maryland
	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)	-			1	18. Mother's	Name (F	First, Middle,	Maiden Sum	ame)	•
ylai	should be ind Mental marked o	To	George A. Brown					Sara					
Maryland	2 sho		19a. Informant's Name/Relationship (T)							Route Number			p Code)
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, Ite Medical Exarts are rived by inclined at		Charles A. Rich	ardson J	20b. Place of Dispo			ne Av	e, I	Balti	nore,		21207 own. State
altimore,	Pages nent of H int: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ F		cemetery, cre	matory or ot	her place,						
Ħ			4 ☐ Donation 5 ☐ Other (Specify) Z1. Signatore of Funeral Service Licens		New Ca	athed 2. Name and			30/	2007	Balt	imore	e, Md
Ba	permit. Departr Importa any inju		> XIMMIN (MILLE	Ad I	March	F/E	1 Wes	t	D = 3 + .	:	N/ -7	21215
	_		23a. Part1. Enter the disease, or compleshook, or heart failure. List only o	ications that caused th	e death. Do not en	ter the mode	waba of dying,	ASN_A , such as ca	rdiac or r	Balt: espiratory arr	est,	, MO	Approximate Interval Between
	Physician		Immediate Cause (Final	Phouse	nnnia								Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):			à					
	Examiner		Sequentially list conditions	. Chronic	c Obstr	16tive	2 Pu	umor	ari	1 Dis	2050		
	D ==	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):				_)			
k	and -trans	каш	that initiated events resulting in death) Last	Due to (or as a c	consequence of):								
760,	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	calE			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
687		2000		d									
Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of		75					23d. l	Date of deliv	very
	death e atte	Physician/Med	in the past 12 months?	1□Live birth 2 4□Pregnant at tir 9□Unknown		□Ectopic pre □ Other (spe						Month	Day Year
P.0	at the by th	hys	9 □ Unknown							T			
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by	Part II. Other significent conditions co	ntributing to death but	not resulting in the u	inderlying ca	ause giver	n in Part !.		238. Did to		3 ☐ Pro	the cause of death?
ord	requii	ted									-		
Records,	e law has b	Completed						-	_	24a. Was a autops perfor	SV .	 b. Were aut prior to o death? 	opsy findings available ompletion of cause of
										1 🗆 Yes	2 2 010	1 🗌 Yes	2 No
V:	Physician: The law this certificate has be ral director, page 2 s	Be C	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatie	nt 3 DO	Other			Check only or 5 ☐ Reside		ther (Spec	ih/l
of	> 20	n: To	27. Manner of Peath	28a. Date of Injury (Month, Day)			Bc. Injury a Work?		-	d. Describe h			ay)
ion	Attending I or death. ector: After by the funer	atio	1 Abatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)	(ear) Injury	М		es 2□No					
Division of Vital	r Atte er dei recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	- At home, farm, st (Specify)	reet, factory	, office		28	Location (S City or Tow	treet and Nu n, State)	mber or Ru	ral Route Number,
	ital o irs aft ral Di lled in	Cer											
	To the Hospital or Attending Phwithin 24 hours atter death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of e	xamination and/or in								
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner state	a.	29c.	License	number		2	9d. Date sig	ned (Month	, Day, Year)
	Z Z Z S		() Jan 1	Man	MO		Dm	564	14		7-7	7-1	7
	m		30. Name and address of person who co	ompleted cause of dea	th (Item 23a) (Type,	, Print)		307	1 7			1 - 0	
	")		Torolun E	i-Saved.	MD, MPH	16 F	ustin	g Au	onue	Bal	timon	o M	D alzzg
	→ Sta	ate	31. Date filed (Month, Day, Year)	34 Registrar	s Signature	a. 0. 1	-)		,			
341	Regist	rar	MAR 2 9 200	filling	15 190								

DHMH 17 Rev 1/2001

			State of Maryland / De	epartment of Health and No Certificate of Death	/lental Hygiene	bnn7 nagali
			Registrar C	Dertificate of Death	Reg. No.	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last)		Month Day	y Year
1	/Medic	6	Alejandrina Gonzalez	Ramirez 4b. City, Town, or Location of Death	3 22	2007 3:23p M County of Death
	Examin	er	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	Baltimore	40.	NA
5	Francisco Control		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Q Birthplace (State or Foreign
Н	Funeral Director		NA 1□M 2□F 49 Yr	Months Days Hours Min	(Month, Day, Year)	958 Mexico
			Usual Residence of Decedent		2 21 1	
	rylan how		10a. State 10b. County 10c. City, Town of			10d. Inside City Limits
	e Ma 3a-f s tified	당	MD NA Balti	more		1 X Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citi	izen of What Country?
	ath w	<u>ra</u>	247 S. Broadway	21231		Mexico
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	 Race - American Indian, Black, White, etc.
36	s afte	by F	1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Hispanic
8	hour Itural	g l	15 Decedent's Education 16a. D	ecedent's Usual Occupation	16b. Ki	ind of Business/Industry
15	in 72 n "na n "na nedic	plet	(Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed)	Give kind of work done during most of work ife. DO NOT use retired)	king NA	NA
212	d with giene r tha	Completed	NA NA			
Þ	al Hyg othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden	Surname)
<u>lar</u>	uld b Venta rrked rric e	၉	Telesforo Gonzalez	Gregor	ia Ramir	ez
an	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	•	Husband	Mailing Address (Street and Number or Rui		·
≥,	and and n 27		Amado Acevedo-Baltazar	-		21231
ore	Pages 1 Tent of H nt: If Itel		20a. Method of Disposition 20b. Place of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State 7 □ P □ V	crematory or other place)		ocation - City or Town, State
Baltimore, Maryland 21215-0036			4 Donation 5 Other (Specify)			elos, Mexico
3a	permit. Departi Importi any inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	March Eas	-
	□□ = # 0		Enancium Control of the death of the	1101 E. North		
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	>		s days
	/Medical Examiner		Due to (or as a consequence of)		S Summ	me 2 dring
€.		P.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)	ii (PISNE	>> >qvvvo	me samp
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of) that initiated events c.			
Ć,	exector and and ial-tra	Exa	resulting in death) Last):		
760,	Attending Physician: The law requires that the death certificate be executed death. death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	g				
68	tifica ng ph as th	ledi			1	
Вох	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death	3□Ectopic pregnancy	:	23d. Date of delivery Month Day Year
	e dea he at ied fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	5 Other (specify)		Month Day Year
P.0	at th	Physician/Med	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	he underlying equae given in Dort I	220 Did tobacca I	use contribute to the cause of death?
S,	ires that the de signed by the a l be detached f	<u>م</u> ا	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Fait i.		No 3 Probably 4 Unknown
0	w require been sign	ed		· · · · · · · · · · · · · · · · · · ·		
3ec	e law has t je 2 s	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a	n: Th icate r, pag	ပိ			1□ Yes 2 No	
Σ	Physician: The la or this certificate has oral director, page 2	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outp	Other:	th (Check only one)	0 Flour (0
o	Phy er this eral d	: To	27 Manner of Death 28a, Date of Injury 28b, Tir	me of 28c. Injury at	ome 5 Residence 28d. Describe how injur	
0	nding P th. r: After i e funera	ıtior	↑ Matural 5 Pending (Month, Day Year) Inju	M 1 Yes 2 No		
Division or Vital Records,	Atternation of the part of the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number,
	tal or s afte al Dir ed in	Sert	Sanding, etc. (apoetry)			,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fur	cal	29a. Certifier (Check only (C			
	the I	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d Dai	tte signed (Month, Day, Year)
	Wit Co		250. Orginative and time of certainer	DCC		1 -01
	19		pas pas	Pro Print	Marc	L 28, 2007 Veryland 21787
	2		39. Name and address of person who completed cause of death (Item 23a) (T	rates Stroof Paril	tomano In	(ma) and 21757
	Sta	ite	31. Date filed (Month, Day, Year) 3. Registrar's Signature	Analla 2	TIPION C P	wight too 7
	Registi	-	MAR 2 9 2007 Boson &			

State of Maryland / Department of Health and Mental Hygiene

	1.	For State Of War Registrar		ertificate of L	Death	R	eg. No:	107	n o o o
Physician	1.	Decedent's Name (First, Middle, Last) NILHELM	RAIN	Conn		2. Date of Dear	2 S	Year 2007	1245 A
/Medical Examiner	48	Facility Name (If not institution, give street and number) Levindale Nursing Cent		4b. City, Town, or Balti	more			ity of Death	ace (State or For
Funeral Director		215-38-8569 ¹≅ ^{M 2□F}	In yrs. last birthda 80 Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Jan4,	1927	Pol	and
Aaryland f show ed at	10	sual Residence of Decedent)a. State	Oc. City, Town or Mido	Location lle River				1	0d. Inside City Lir 1 □ Yes 2 ☐
frer death with the Mar r items 23a or 28a-f sh iner must be notified ineral Director	10	De. Street and Number 928 Susquehanna Avenue		10f. Zip Code 2122			US		
rs a		1. Marital Status 1	cify Yes or No- Rican, etc.)	Spe		etc. ite			
ed within 72 houygiene. Ner than "natura Ner the Medica E t, the Medica E	-	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Gi life	cedent's Usual Occup ive kind of work done of e. DO NOT use retired	during most of workii	ng		Business/Indication	
otal Hyger and other event,	3 1	7. Father's Name (First, Middle, Last)		JSArmy	18. Mother's Name	(First, Middle,	Maiden Surr	name)	
t and z should be the tend of the tend of the tend Mental tend other traumatic every the tend of the t		Dionysius Raimund 19a. Informant's Name/Relationship (Type. Print) Toyce A. Raimund /wife		ailing Address (Street Susqueh	and Number or Rura				
ages I allo	100-	0a. Method of Disposition 1 ☐ Burial 2 ☐ € remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dis	sposition (Name of crematory or other place or Crematory	ce)	7 / 0 7	20c. Location	on - City or To	own, State
Dentill. rages Department of h important: if ite any injury or ot once.		21. Signature of Funeral Service Licensee	7	22. Name and Addre				.Balt ssex	imore 21221
hysician /Medical Examiner		resulting in death) Due to (or as a	TENTIA consequence of):		ng, such as cardiac c	r respiratory at	11031,		Interval Betwee Onset and Dea
ean cernicate be executed attending physician and for use as the burial-transit clar/Medical Examiner	Icai Examine	rany, leading to finited late cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):						
e attending d for use a	/sician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 🗌 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	у		23d	. Date of deliv	/ery Day Yea
igne d	5	Part II. Other significant conditions contributing to death but	at not resulting in th	ne underlying cause gi	ven in Part I.				the cause of dea
has by	Completed					1□ Yes	2 No	24b. Were au prior to death? 1 □ Yes	topsy findings ava ompletion of caus 2 No
certificate rector, page	Re	25. Was case referred to medical examiner?	nt 2 ER/Outpa	ationt 3 DOA Ot	26. Place of Deather:			Other (Spec	cifv)
hys	01: 10	27. Manner of Death 12 Natural 5 □ Pending (Month, Da)	ry 28b. Tin	ne of 28c. Injury		28d. Describe			
at at	Certification:	3 Suicide 6 Could not be determined 28e. Place of inj building, et	c. (Specity)	n, street, factory, office		City or To	own, State)		ral Route Numbe
Hosp 4 hou Fune tely fil	Medical C	29a. Certifier (Check only one) Check only one)	examination and/	or investigation, in my	opinion, death occu	, and due to the rred at the time	s, date and pr		
To the within 2 To the comple	Me	29b. Signature and title of certifier 30. Name and address of person who completed cause of c		000	64533		03	1251	h, Day, Year)
5		BABATUMDE M. AJAT	leath (Item 23a) (T	ype, Print) LEVIN	Benjeder	SETW he	RIATE, BALT	in ch	m) 212
state Registra		31. Date filed (Month, Day, Year) MAR 2 9 2007	ar's Signature	park					

Theodore Ryder 07-02266

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK UNK	1- For State Certifi	nent of Health and Mental Hyg cate of Death	lene 2007 09986						
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year 0940 hrs						
Medical Examiner	Theodore C. Ryder Sr. 4a. Facility Name (if not institution, give street and number)	4b. City. Town, or Location of Death	March 24, 2007						
	26 Country Club Lane	Phoenix	Baltimore County						
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last b	Months Davis Hours Min	B. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Foreign						
Director	217-90-2721 1XM 2 F 45	Yrs. Months Days Hours Min.	MD Country MD						
any	Usual Residence of Decedent 10a State 10b. County 10c. City, Tow	n or Location	10d. Inside City Limits						
ž ,	MD Harford Jop	pa	1 Yes 2 XNo						
the Maryland a or 28a-f show tifted at once.	10e Street and Number	10f. Zip Code	10g. Citizen of What Country?						
	417 Shore Drive	21:085	USA						
r death with or items 23 invest be no	11. Marital Status 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric 							
her des ", or i er mu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	_{Specify:} White						
ours aft atural" xamine	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired	done 16b. Kind of Business/Industry						
0036 within 72 hour giene. Her than "natu ter than "natu ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	Owner	Aero Roofing						
-003 d withi /giene. ther th	17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Surname)						
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death wiment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be To Be Completed by Funera	James F. Ryder Sr.		Johnson						
D 21 should is ma atic ev	, , , , , , , , , , , , , , , , , , , ,	9b. Mailing Address (Street and Number or Rura							
mand 2 sho lealth and tem 27 is traumati	Monica Ryder / wife 20a Method of Disposition 20b Plac	417 Shore Drive Jo	ate 20c. Location - City or Town, State						
10re ages l nt of H nt. If i	1 X Burial 2 Cremation 3 Removal from State HOI	latory or other place) Ly Hill Cemetery 3/	28/07 Baltimore MD						
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mendal Important: If item 27 is marked injury or other traumatic event,	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22 Name and Address of Facility 300 Mace Ave.Balto. MD								
M FOLE	Valuet & pers	Connelly Funeral	Home of Essex 21221						
Physician /Medical	23a. Part I. Enter the disease, or complications that dused the death. Do failure. List only one cause on each line.	not enter the mode or dying, such as cardiac or re	Between Onset and Death						
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):								
	Sequentially list conditions, b								
ine in	if any, leading to immediate cause. Enter Underlying Cause c. Due to (or as a consequence of):								
ted Insit Examiner	events resulting in death) Last Due to (or as a consequence of)								
0, be executed sician and ourial - transi	UNPENDED AMENDED								
60, ate be ohysicia buria	IF FEMALE: 23c. If yes, outcome of pregnand	cy	23d. Date of delivery						
b. Box 6876i the death certificate by the attending phy ched for use as the t Physician/Mi	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death	 Fetal death 3 Ectopic pregnance Other (Specify) 	y Month Day Year						
Box death he atter of for u	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)							
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after decrease. The law requires that the element Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Physician/Medical Existence.	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown						
S, P puires t m sign lid be			24a. Was an 24b. Were autopsy findings available						
Records, The law requires freate has been sig			autopsy prior to completion of cause of death?						
tal Rection: The certificate ector, page	25. Was case referred to medical	26.Place of Death (Check onl	1 Yes 2 No 1 Yes 2 No						
Vital Rechysician: The lathic certificate la director, page	everiner?	Oth -	Home 5 Residence 6 ✓ Other: Scene						
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Sion Attendide death ctor: / y the fi	1 Natural 5 Pending POUND: Mar 24, 2007	930 hrs	3f. Location (Street and Number or Rural Route Number, City						
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Di Standard Di Standard Funeral Standard Stand Standard Stand Standard Standard Standard Stand Stand Stand Stand Stand S	Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and du	ue to the cause(s) and manner as stated.						
Division of To the Hospital or Attending Ph within 24 hours after death To the Funeral Director. After the Completely filled in by the funeral Medical Certification: T	(Check only one) Medical Examiner: On the basis of examination and/	or investigation, in my opinion, death occurred at t	he time, date and place, and due to the cause(s)						
To with To con	29b. Signature and the of certifier	29c. License number	29d. Date signed (Month, Day, Year) March 25, 2007						
	- HOVY	O.C.M.E.	Watch 25, 2007						
10	30. Name and address of person who completed dause of death (Item 23 Susan Hogan MD. Assistant Medical Examiner	^{a)} 111 Penn Street, Baltimore, MD 2120	01						
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	paile)							
Pagistra	3550 9 0 2007 Basica At A	Mark Comments							

			For State Registrar	State of Ma	aryland		artment of F			tal Hygier	711111	09987
	Physici /Medic	al	1. Decedent's Name (First, Middle,	n Rand	all		4b. City, Town, o	r Location o		03 2	Day Yeer 3 200 4c. County of Dea	3. Time of Death
	Examin Funeral Director	ier	Harbort	Pospital	e (In yrs. la:	st birthday) Yrs.	Boult If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. [Min. (Date of Birth Month, Day, Ye	9. Bi	rthplace (State or Foreign country)
	<u> </u>		Usual Residence of Decedent 10a. State 10b. County	AA		Town or Lo	ocation		110	2, 1520	<u></u>	10d. Inside City Limits
	the Man 28a-f sh notified	Director	MD 10e. Street and Number		BAL	TIMORE	10f. Zip Code			10g.	Citizen of What C	1 Tyes 2 No
	death with ms 23a or must be	Funerai Di	1234 PATAPSCO ST.	12. Was Decedent I	Ever in U.S.	. 13.	21230 Was Decedent of H		igin? (Specify	USA cify Yes or No- 14. Race - American Indian,		
900	hours after death with the Maryland tural; or Items 23a or 28a-f show al Eranities must be netitied at	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Agried Forces? 1 Tyes 2 N If Yes, Give Year or Dates:	No		If Yes, specify Cuba 1 ☐ Yes 2XXNo			in, etc.)	Black, Wh	##1TE
21215-0036	be filed within 72 hours after death with the Marylan Hygiene. Hygiene. do ther than "netural; or items 23a or 28a-f show event, Ite Medical Eventral near man be notified at	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		i+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SHEET METAL MECHANIC			t of working	16b	. Kind of Business	
		Be	11 17. Father's Name (First, Middle, L			SHEET	I METAL MEC	18. Mothe		rst, Middle, Maid	CONSTRUC (en Sumame)	MUII
Maryland	12 should hand Me	오	19a. Informant's Name/Relationsh		TED		ng Address (Street	and Numbe		ute Number, Cit	y or Town, State,	Zip Code)
Baltimore,	ges 1 and to f Healt if item 2 or other		CLORIA BOND 20a. Method of Disposition 1 Burial 2 Commation 4 Donation 5 Other (Sp	3 □Removal from State	20b. Pla	ce of Dispo	psition (Name of matory or other place MATORY, IN	ce)	Date 3.27.20	20c	Location - City o	
Baltir	permit. Pa Departmen Important: any injury once.		21. Signatur 3 Funeral Savic	NVK	M0114	22 F I	2. Name and Addre	HOME,	P.A.			
B760, Cate be executed Wedical Examiner The burial-transit		icai Examiner	23a. Part. Enter the disease, or shock, or heart failure. List of limmediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a conseque	Do not enter ence of):			-			Approximate Interval Between Onset and Death 7 / Yellow 10 days
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rds, P.O.	as ng	by	Part II. Other significant condition	ns contributing to death be	ut not result	ing in the u	nderlying cause gru	en in Part I				to the cause of death? Probably 4 Unknown
al Records,	The ate he page	Completed		01						24a. Was an autopsy performed 1. Yes 2	? prior to death?	
f Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 E	R/Outpatier	nt 3 DOA Oth	100		neck only one) 5 Residence	6 ☐Other (Sp.	ecify)
on of	ling After une		27. Manner of Death Natural Accident S Pending investig		ry y Year) 2	8b. Time o Injury	Wor	ryat rk? Yes 2. □		Describe how in	njury occurred	
Division	or At offer of Direction by	Sertification;	3 Suicide 6 Could n 4 Homicide determi			ne, farm, str	reet, factory, office			Location (Street City or Town, St		Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai C		Physician: To the best of examiner: On the basis of and manner sta	examination							
	within Comp	W	29b. Signature and title of certifier	salati			29c. Licens	e number	72	29d.	Date signed (Mon $3/23$)	nth, Day, Year)
1	/ γ		30. Name and address of person y	Saluti	eath (Item 2	S. H	andver	9.10	Baltir	nove 1	1d.21	225
	Sta Registr		31. Date filed (Month, Day, Year)	sho completed cause of d SQUAL 32 egistra 2007	ar's Signatu	A A	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Chester Leroy Ruby 12:01AM 21, 2007 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Manor Care Nursing Home Baltimore County Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-27-1913 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min Days Hours 1⊠M 2□ F 213-03-4139 93 Yrs. Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21204 7001 N. Charles Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII XXNever Married 2 ☐ Married 1 ☐ Yes 2KD No à Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Swim & Golf Club Clubhouse worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Louise Gill William Ruby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health ar Important: If item 27 is 1 any injury Elmer Plumhoff 995 Point Pleasant Road Glen Burnie, MD Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1K Burial 2 ☐ Cremation 3 ☐ Removal from State Veteran Cemetery 3/27/07 Owings Mills, MD Garrison Forest 4 ☐ Donation S ☐ Other (Specify) uneral Service 21. Signatur l io BURGEE-HENSS-SEITZ Funeral Home 3631 Falls Road Baltimore, MD 2 o not after Approximate Interval Between Onset and Death Part I Inter the diseas shock, or heart failute the mode of dying, such as cardiac or respiratory arrest, e, or complications to List only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA A□ Nursing Home 5□ Residence 6 □Other (Specify) Certification: To 28d. Describe how injury occurred

death certificate be executed and burial-trar Box 68760, physician the as attending ase for P.O. ed by the a signed by t Division or Vital Records, page 2 should certificate has this funeral c After t Hospital or Attendi 24 hours after death. Funeral Director: A death.

1 and 2 should be filed within 72 hours after dealth and Mental Hygiene.

Maryland 21215-0036

Saltimore,

27. Manner of Hura 2 Accident

3 Suicide

29a. Certifier

one)

30. Name and addre

4 Thomicide

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signat

MAR 29

29c. License number

29d. Date signed (Month, Day, Year)

Day, Year,

32, Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

and manner stated.

State Registrar

filled in by the

24 hours a

To the I within 2

				State of Marylar	od / Donarte	nent of Health	and Montal k	_	7 00000		
				er PHY G865 3	Certifi	cate of Death	2. Date of	Reg. No U U	1 03303		
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>	/Medic Examin		4a. Facility Name (If not institution, give s		4b.	City, Town, or Location	of Death	4c. County of			
				Court Apt.		Parkvill	0		timore		
	Funeral		5. Social Security Number 6. Sec. 15. 219 • 22 • 0570	7. Age (In yrs.		Under 1 Year If Under on the Days Hours	Min. (Month	Birth S Day, Year)	Birthplace (State or Foreign Country)		
	Director		Usual Residence of Decedent		00		0.5	12.1927	3110		
	anylan show del	_	10a. State 10b. County		ity, Town or Locatio				10d. Inside City Limits 1 ☐ Yes 2 ☑No		
	the Ma	ecto	MD Baltin	iore		LVIII-O Of. Zip Code		10a Citizen of Wh			
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show or other traumatic event, the Madical Examinat mail by modified at	Funeral Director	8722 Stockwell	Road	["	21234		10g. Citizen of What Country?			
	teme.	uner	T. Walter States	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was	Decedent of Hispanic Or , specify Cuban, Mexica	igin? (Specify Yes or n, Puerto Rican, etc.	No- 14. Race - Black,	American Indian, White, etc.		
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1	101	es 2540 Specify:	:	Specify:	Black		
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an	id be ked o ic eve	To Be	John H. Finch				1 1	rower			
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Ma	-	19a. Informant's Name/Relationship (Ty	/ /	1	Idress (Street and Numb	er or Rural Route Nu	mber, City or Town, St	ate, Zip Code)		
	l and lealth		Rosalind L. Ho	use/Daughte	_	, ,	unt Apt.				
Kosalina L. House Daughter 2907 Andorra Court Apt. 13 Farkville MD 2002. Location - City or Town, State 2002. Method of Disposition 1 Date 2002. Location - City or Town, State 2002. Method of Disposition 1 Date 2002. Location - City or Town, State 2002. Method of Disposition 3 Removal from State 2002. Method of Disposition (Name of cometery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral 2002. Name and Address of Facility Vaughn C. Greene Funeral 2002. Name and Address of Facility Vaughn C. Greene Funeral 2002. Name and Address of Facility Vaughn C. Greene Funeral 2002.											
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À	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ENU ST	AGE C	HOUIC	OBSTIL	UCTIVE	5		
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	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
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J Of	ding Phys	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		be how injury occurred	(Specify) Residence		
Division	ttendin death. ctor: Af	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		N	1 Yes 2	No				
2 Accident 3 Suicide 4 Homicide 6 Could not be determined 5 building, etc. (Specify) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rura City or Town, State)									or Rural Route Number,		
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	nor in			ner: On the basis of examina	ation and/or investig	ation, in my opinion, dea	ath occurred at the tir	ne, date and place, an	d due to the cause(s)		
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	Physici /Medio		Geraldin	e L. Reha	k			MARCIA	25 200	
	Examir		4a. Facility Name (If not institution,			-	or Location of Death		4c. County of Deat	th
				-	CZNICK		1 MORE			
	Funeral Director		5. Social Security Number 217-26-5918	5. Sex 7. Ag 1 ☐ M 2 【 F	e (In yrs. last birti 93 Y	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 29,	1914 9. Bird	thplace (State or Foreigr Suntry) Maryland
			Usual Residence of Decedent					Out 25,	1314	riat y rana
	how		10a. State 10b. County		10c. City, Town					10d. Inside City Limits
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	th with th	al Dire	10e. Street and Number 2802 Pinewood	Ave.		10f. Zip Code 2121	4	10	Og. Citizen of What Co USA	-
	dead dead	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Spe can, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9500-61212	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinational be notified at	Completed by Funeral Director	1 Never Married 2 Marrie 3 XWidowed 4 Divorced		No	1 ☐ Yes 2 ☐ X No			Specify:	White
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ē,	s 1 a otha		20a. Method of Disposition		20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ace)	ate	20c. Location - City or	Town, State
Ē	Page nent c nt: If		1 X Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (Sp			ridge Mem P		07	Elkridge,	Md.
Baltimore,	permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or othar traum <u>once</u> .		21. Signature of Funeral Seni)ce L	ensee		22. Name and Addr RUCK 1050 Y	owson Fune	eral Hom bwson, M	e, Inc. d. 21204	
á.	Physician /Medical Examiner		23a. Part 1. Enter the disease, of a shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	respiratory arre		Approximate interval Between Onset and Death				
68/60,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c Due to (or as a consequence of): d						
O. Box 6	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 p/fonths? 1						23d. Date of delivery Month Day	
1	s that ned b	y Pt	Part II. Other significant condition	s contributing to death b	ut not resulting in	the underlying cause g	iven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
g	quire n sig uld be	d be						1 □ Y€	s 2 1 1 1 1 0 3 □ P	robably 4 Unknow
Records,	The law reite has bee age 2 sho	Completed by						24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical				26. Place of Death			
_	Physician: this certific ral director,	ToE	examiner?	Hospital: 1 Inpatie	ent 2 ER/Out	tpatient 3 DOA	ther: 4 Nursing Ho	me 5 Reside	ence 6 Other (Spe	ncify)
lon of	ling After une	atlon:	27. Manner of Death 1	ition	ry Year) 28b. T	ime of 28c. Injury W	ury at ork?	28d. Describe ho	ow injury occurred	
DIVISION	al or Atte after de Directo d in by th	Certification:	3 Suicide 6 Could not determine	200. Flace UI III]	ury - At home, fai c. (Specify)	rm, street, factory, office	3	28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	f examination and	, death occurred at the d/or investigation, in my	time, date and place, opinion, death occurr	and due to the ca	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
1	To the within 2 To the complet	29b. Signature and title of certifier M2DICAL ATTENDING 29c. License number DODG 235 MARCH 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR MAN PARG 00, MD BAC GGW315 // BMEWOOD CZWZZM, 6000 BELLONA AUE, MD								
2	1		30. Name and address of person w	ho completed cause of c	leath (Item 23a) (Type, Print) DR	MANU NAIN	4 001	MD RA	LTIMORS
2				BHEWOOD		22M. 60	०० ४२८	CONA.	AUE, M	021212
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	A M. a				

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 50 AM Month 3 26 FREDERICK 07 4c. County of Death 4a. Facility Name (If not institution, give street and number) South river Health and 4b. City, Town, or Location of Death Anne Arundel Rehab Edgewater 8. Date of Birth (Month, Day, Year) 2-19-1921 If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Age (In yrs. last birthday, 86 Yrs. Social Security Number 22005824 Days 1**X**M 2□F MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State MD Anne Arundel Odenton 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 Bruce Avr 21113 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 【 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 □ Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOME IMPROVEMENT PAINTER 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) AMELIA ELIZABETH OBERDORFER UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 BRUCE AVE. ODENTON, MD 21113 19a. Informant's Name/Relationship (Type. Print) MARY A. MARTZ / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MARCH 2087 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE, MARYLAND 4 □ Donation 5 □ Qther (Specify) CROWNSVILLE MD VET. CEM 21. Signature of Funeral Se 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 21061 0 GLEN BURNIE, MD 421 CRAIN HWY. SE.; Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final day disease or condition resulting in death)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

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Director

Funeral

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit

Certification: To Be Completed by Physician/Medical

Medical

Division or Vital Records, P.O. Box 68760, 💉

	Due to (or as a consequence of):	0
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):	
that initiated events ' resulting in death) Last	C. Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery Month Day Year
Cheonic Re	nal Failule, Diabetes,	te. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nhnow
Anemia, t	lypertention, Demention 24	a. Was an autopsy performed? ☐ Yes 25500 24b. Were autopsy findings availab prior to completion of cause of death? ☐ Yes 25500
25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Surviving Home 5	☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Autural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of linjury at Work? 1 □ Yes 2 □ No	escribe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At nome, famil, street, factory, office 28f. Loc	cation (Street and Number or Rural Route Number, y or Town, State)
	ysician: To the best of my knowledge, death occurred at the time, date and place, and dunliner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	

State Registrar

RITA DHAWAN, MD 31. Date filed (Month, Day, Year)

MAR 2 9

29b. Signature and title of certified



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

21043 ELLICOTT CITY, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 27, D2007 **Physician** 2:40 P. M Leonard S. Sullivan, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7820 Oakwood Road Glen Burnie Anne Arundel Hours Min. 8. Date of Birth (Month Pay, Mar.) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Mary Tand 218-28-5873 74 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 □Yes 🏋 🗓 No Maryland Anne Arundel Glen Burnie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 United States 7820 Oakwood_Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No
If Yes, Give
Year or Dates: KOREA 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify. Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Depatrment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Sullivan Hazel Cameron ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garnett A. Sullivan / Wife 7820 Oakwood Rd., Glen Burnie, Maryland 21061 March 31, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Pk. 2007 Glen Burnie, Maryland 4 □ Denation 5 □ Other (Specify) Kዊተሉገድሚላዊ ማቸናዊ የLuneral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 21. Signatule of Funeral Service Licensee Chi Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cancer anc month **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the bunial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 ☐ Other (specify) 9□Unknown 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2N No 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: (Month, Day Year) 1 🔼 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funeral C 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D39505 an M.D March 28, 2007 10 Hospital Dr. Glen Burnie MD. 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 dhish 32. egistrar's Signature 31. Date filed (Month, Day, Year) State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #10e, perFH, g866,4/2/07 TT 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Soden-Allen Margaret March 6:00 AM \$6,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore A 3409 Ellamont If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) NOVEMBER 15,1912 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days 1 ☐ M 2 📉 F 94 Maryland 215-28-5544 Director Usual Residence of Decedent r 28a-f show notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Baltimore 1 Yes 2 No Maryland Director 10e. Street and Number 3609 Ellamont Rd. 10f. Zip Code 10g. Citizen of What Country ms 23a or United States 21215 Road Ham on t by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian r than "natural", or items the Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) -1brara Kevisor other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental H Item 27 Is marked oth r other traumatic even Bessie Stewart Waters George ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Johnson-Daughter Randallstown, Margland 21133 30 Hubart Court or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park March 20c. Location - City or Town, State 20a. Method of Disposition 31 ofi 1 Burial 2 □ Cremation 3 □ Removal from State Butomore, Marglard Department of Important: If any injury or 2007 4 Donation 5 ☐ Other (Specify) 22, Name and Address of Fadilix ans Funeral Service, P.A. 21. Signature of Funeral Service License Calvin L. Williams Funeral Maryland 21299 -win Z. M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardioyasaler **Physician** one year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate source. Enter or sering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes carce 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Mann f Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 atural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident after death Director: the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 023466 29 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark T. Highes, MD 4 Baltmore, MD Caroline JHOC KOOM 2143 21287-094

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 9 2007

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** March 2007 SIMONA SAVOY-MCLEE /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 4a. Facility Name (If not institution, give street and number) Good Samaritan Dal timore 5. Social Security Number if Under 1 Year | if Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2XX Yrs. MARYLAND Director JUN 25 1955 212-60-8916 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director BALTIMORE MARYLAND N/A10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3413 MARY AVENUE APT A. 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②ZXNo if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo ģ Specify: BLACK 3 ☐ Widowed 4 🖾 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT CLAIMS SPEC 2yrs 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be RAYMOND SAVOY BERTA BROOKS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 St. Agnes Ln, Baltimore, Maryland 21207 Ventura McLee/Ex-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 03-31-07 BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify, METRO CREMATORY 21. Signature 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that code d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on page line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hour disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's consequence off Examiner certificate be executed as the burial-transit and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Maprier of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No al or Attend after death. 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State

31. Date filed (Month, Day, Year) 22. Registrar's Signature MAR 2 9 2007

mpleted cause of death (Item 23a) (Type, Print)

Registrar

139543 Murch 26, 2007 Lab Peven Bonlevard Beltmars, Manylon Paul E. B. Sorensen 07-02267 **UNK UNK**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar Registrar									
Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2040 by a									
dical Examin		Paul E. B. Sorensen March 24, 2007 0940 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 14c. County of Death									
		26 Country Club Lane Phoenix Baltimore County									
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Poreign MD)									
Director		213-74-2723 x M 2 F 48 Yrs. Jan24, 1959 Country) MD									
any	ŀ	Usual Residence of Decedent 10a. State									
* "	۱	MD Harford Joppa 1 Tyes 2 X No									
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
	- 1	105 Ravenwood Court 21085 USA									
eath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. 2 Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.									
after d	면 도	1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year of Inc. 2 No specify: Specify: White									
hours	9	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)									
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	Be	Kjeld Sorensen Anne Liele									
MD 2: Id 2 should lith and M is 27 is m]٤	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Ravenwood Court Joppa MD 21085									
4 E 8 B E		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State									
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tringer.		1 X Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 3/28/07 Baltimore MD 4 Donation 5 Other Specify:									
taltil		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave.Balto. MD									
	4	23a Part I. Enter the disease, or complications that caused by death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval									
Physician /Medical		failure. List only one cause on each line. Between Onset and Between Onset and Between Onset and									
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):									
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated									
Tied A		events resulting in death) Last Due to (or as a consequence of): d.									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED									
760, icate by physicate but the but		IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live high Day Year									
Box 687 death certific	cian	past 12 months? 4 Pregnant at time of death 5 Other (Specify)									
Box ne death the att	Physician	1 Yes 2 No 9 Unknown 9 Unknown									
P.O. B	و م	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown									
ords, P w requires the seen signs should be d	ed	24a. Was an 24b. Were autopsy findings available									
e law re has b	Completed	autopsy prior to completion of cause of performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No									
tal Rec	ø	25. Was case referred to medical 26.Place of Death (Check only one)									
Vital hysician: this certifi	9 P	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other. Scene									
Division of Vital Records, tal or Attending Physician: The law requirers after death. In the take the second and Director: After this certificate has been similar in by the funeral director, page 2 should be		27. Manner of Death 28a. Date of Injury Month: Day, Year) 1 Natural 5 Pending 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 1 Yes 2 No									
isior Attend or death rector: by the	igat;	Accident Investigation Mar 24, 2007 0930 hrs 28e, Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City									
Divis Hospital or A 24 hours after Funeral Dire	Certification:	Suicide 6 Could not be determined (Specify) Single home (yard) Or Town, State) 26 Country Club Lane, Phoenix, MD									
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To the within 7 To the comple	Medical	29b. Signature and tiple of certified 29c License number 29d. Date signed (Month, Day, Year)									
		O.C.M.E. March 25, 2007									
		30. Name and address of person who comply ted cause of death (Item 23a)									
4		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
Sta Registi		31. Date filed (Month; Day, Year) 32. Degistrar's Signature									
DHMH 17 Rev 1/20		ORIGINAL									

		For State		State	of Mary	land / I		rtment		ealth and N	-	-	007	n a a	106
		1. Decedent's Name	First Middle	a. Last)		-	001	incate	0, 0	Cuiri	2. Date of De	Reg. No.	.UU/	3. Time of	Death
Physi /Med		boooding right	, (r not, moon		ard Cu	rtis	Smit	h, Sr	•		Month March	Day		1:00	
Exam		4a. Fecility Name (If	not institution	, give street and	number)			4b. City, To	own, or L	ocation of Death		4ç. (County of Dea	th	
		Charlott	e Hall	Veteran	s Home	2		Char	lott	e Hall		St	. Mary	's	
Funera Directo		5. Social Security No. 223-28-5		6.Sex 1 ☑ M 2 ☐ F		yrs. last bi	rthday) Yrs.	If Under 1 Months I	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan 8,	iy, Year)	C	thplace (State or ountry) rginia	r Foreign
ס		Usual Residence of									, , , , , , , , , , , , , , , , , , , ,				
nylan how		10a. State	10b. County		10	c. City, Tow	n or Lo	cation						10d. Inside Cit	
a-f-	Ş	MD	Howar	d		Laure	1							1 🗌 Yes	241 No
th th	Director	10e. Street and Num	nber					10f. Zip C	ode			10g. Citiz	en of What Co	ountry?	
23a	a	82 Midwa	y Aven	ue				207	23			U.S	S.A.		
des	Funeral	11. Marital Status			ecedent Ever Forces?	r in U.S.	13. V	Vas Deceder Yes, specifi	nt of Hisp	panic Origin? (Sp. Mexican, Puerto	ecify Yes or No)- 1	4. Race - Ame Black, Whit		
hours after deeth with the Maryland ural; or Iteme 23a or 28a-f ehow is Exantement must be notified at		t 🗌 Never Marrie	_	ied 1 ∑ Ye If Yes.	s 2∏No Give			☐Yes 25		Specify:		1	Specify:		
ural',	d by	3 Widowed			Dates: 19									White	
n 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				king	16b. Kin	nd of Business	/Industry	
Athir Park	E G	Elementary/Secon	ndary (0-12)	College	(1-4or 5+)				reurea)			II C	7 20057		
led y	ပိ	12 17. Father's Name (Firet Middle	l act)		50	ldie	er		8. Mother's Nam	na /First Middle		Army		
be f ntai h d of	Be								'						
d Mei	2		John Cornelius Smith Annie May Burkholder Ja. Informant's Name/Relationship (Type, Print) Annie May Burkholder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
12 st h en 7 le r	1							-				1.00			
Healt Healt m 2		Edward C		Smith, J				sition (Name		ot Road,	Date		cation - City or		
in to the solution of or o		1 X Burial 2	Cremation	3 Removal fro		cemete	ту, степ	natory or oth	er place))					
t. Pa		4 Donation			/	той н		Cemet			27, 07	Laur	cel, Ma	iryrand	
permit. Pages 1 and 2 should be filed within 72 har Deportment of Health and Mental Hygiene. Important: if I fem 27 le marked other then "nature my Injury or other treumatic event, I'm Medical.	S S S S S S S S S S S S S S S S S S S	21. Signature of Fur	neral Service	nsee			Do	Name and	on I	Tuneral	Home, P	.A.		202 420	0
		23a Part 1 Enter th	or charge of	complications the		100773				Ave. L			Land 20	Approximate	
		23a. Part1. Enter the shock, or head Immediate Cause (only one cause o	n each line.			,	/	00011 00 00 000				Interval Bety	ween
Physiciar /Medica		disease or condition resulting in death)	n	_a/	12h	ein	1er	<u> </u>	ae	ment	hia -	ad	Vanc	ed	
Examine				Due	to (or as a co	nsequence	of):	· d	. 50						
	- A	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							disease						
ted	- ie	Cause. Enter Under Cause (Disease or i	rlying injury	(()	CO 10	2		vto.		disea	200			:	
be executed sicien and burial-transit	Examiner	that initiated events resulting in death) L		c. Oue	to (or as a co	nsequence	of):		ry	a sea	30				
ate be executed thysicien and the burial-transit	dical E			hy	nex	ten:	Sio	n							
	edic				PUT										
The law requires that the death certific are has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent	pregnant		outcome of p							2	3d. Date of de	livery	
Jeath s ette d for	cia	in the past 12 to 1 Yes 2	months?	4□Pre	e binth 2.⊡ egnant at time			Ectopic preg Other <i>(spec</i>					Month	Day Y	Year
that the ded by the	nys.	9 Unknown		9□ Un	known										
that ned b	by Pl	Part II. Dther signifi	icant condition	ons contributing to	death but no	ot resulting i	in the un	derlying cau	ıse given	in Part I.	23e. Did	obacco us	se contribute t	o the cause of d	eath?
quires n sign	þ	hupe	rlipi	dem	ia						10	Yes 2]No 3∏P	robabiy 4 💢	Jnknown
w requir	ete	\cup ' \mathcal{P}_n	eun	nonic	k .						24a. Was	an	24b. Were a	utopsy findings a completion of ca	available
The larete has	Completed	7,		agia								ormed?	death?		ause of
	ပိ	25. Was case refer	1							26. Place of Dea	1 Yes	2 No	1 🗆 Ye	s 2□No	
Physiclan: rthis certific ral director,	0 8	examiner?		Hospital:	□Inpatient	2 ER/O	utnation	1 3□ DDA	Other		ome 5 Resi		Other (See	northy)	
Physical displays	-	27. Manner of Death			te of Injury onth, Day Ye		Time of		c. Injury a Work?		28d. Describe			-cny)	
th.		1 Natural 2 Accident	5 Pendir investi	9	ontn, Day re	ar)	Injury	м		es 2 □No					
Attending ir death. ector: After by the fune	lfica	3 Suicide	6 🗌 Could determ	not be 28e. Pla	ice of Injury	At home, fa	arm, stre	et, factory,	office		28f. Location (Street and	Number or A	lural Route Num	ber.
d in the	Certification:	4 🗋 Homicide		bu	liaing, etc. (S	оресн у)					City or To	wn, State)			
To the Hospital or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	edicai C	29a. Certifier (Check only	Certifying	ng Physician: To Examiner: On the	the best of m	y knowledg	e, death	occurred at	the time	, date and place,	, and due to the	cause(s)	and manner a	s stated.)
the Pain 24 the F	fedi	one)		and m	anner stated.						3- 20 000				
	Σ	29b. Signature and	of certifie	's l	1			_	License				signed (Mon	tn. Day, Year)	
1		1/2	ru	1 A	un	m	\mathcal{L}		740	2042		03	123	200	7
10		30. Name and addre	ess of person	who completed o	ause of death		\sim	Print)	D.	- T			٧ ١	700	11-10
١		110 Has	pita	1 1700	1 SI		20	7 1	YI)	5092 nce F	redri	Cle	199	U 20	1612
S Regis	State	31. Date filed (Mont	th. Day. Year)	2007	Registrar's	Signature	And	a see					,		
riegis	ATAVI	17	ILU M S	EUVI ME	All Control of the Party	and d	7	-							

DOB 1/8/1924 EDWARD

23, 2007

MARCH

				artment of Health and N	•		00007				
		1 - For State Registrar		rtificate of Death		g. No.	0999/				
		Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death				
Physic /Med		William R. Sullivan			March 15	, 2007	2:30 AM M				
Exam		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Location of Death							
		9039 Sligo Creek Parkway 5. Social Security Number 6. Sex 7.	# 1000 Age (In yrs. last birthday)	Silver Spring If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Montgomer 9 Birtho					
Funera Directo		578-48-5247 Usual Residence of Decedent	73 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Jan 20,	Year) Cour 1934 Wash:	lace (State or Foreign http) ington DC				
ryland how		10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits				
Ba-f.s	Director	DE Sussex	Frank				1 ☐ Yes 2√ No				
with the	F	10e. Street and Number 34509 Virginia Drive		10f. Zip Code 19945	10	g. Citizen of What Cour USA	ntry?				
heeth re 23	era	11 Marital Status 12. Was Decede	nt Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Splf Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ					
urs after all, or ite	by Fur	Armed Force 1 Never Married 2 Married 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 7	□No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White, Specify: Whi					
ire, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiane. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	16a. Dece (Give life.	ident's Usual Occupation be kind of work done during most of work DO NOT use retired)		6b. Kind of Business/Inc	dustry				
ified with the out. The			sal	es manager	- 15: A 1: A 1	automotive					
and Ibe fil Intai H	Be	17. Father's Name (First, Middle, Last) Cornelius Joseph Sullivan	า		e <i>(First, Middl</i> e, M h Marie F						
arylan, should be and Mental	2	19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or Ru.			Code)				
Ma nd 2 s lith an 27 le		Ann Sullivan/daughter		9 Sligo Creek Pkw							
Baltimore, I permit. Pages 1 en Dapartment of Heal Importent: If Item 2 eny Injury or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from Sta 4 ☒ Donation 5 □ Other (Specify)	20b. Place of Disponsite	osition (Name of matory or other place)	Date 2	Oc. Location - City or To	own, State				
Balti permit. Dapartm Importe eny Inju		21. Signature of Euneral Service Licensee	rector S	2. Name and Address of Facility tate Anatomy Board altimore, MD 2120	1 655 W.	Baltimore S	treet				
Physician /Medical Examiner periods printing periods p	cal Examiner	Party. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heert failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
J.O. BOX 687 Ithe daath certificate by the attending phy- lached for use as the	Physician/Medi		2 Fetal death 3 tat time of death 5		23d. Date of delivery Month Day Year						
- 2 2 8	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to									
of VITAL RECORDS, P.O. Inysician: The law requires that the Ins certificate has been signed by the I director, page 2 should be delache	Completed				24a. Was an autopsy perform	prior to condeath?	psy findings available impletion of cause of				
Italian:	Be	25. Was case referred to medical examiner?		26. Place of Dea	h (Check only one						
OT V Physic rthis or	2	1 Yes 2 No Hospital: 1 Inpa	atient 2 ER/Outpatier			ice 6 Other (Specifi	v)				
VISION OF Attending Phice death. Ctor: After the y the funeral	ation:	27. Manner of Death 1 Accident	njury 28b. Time o Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	vinjury occurred					
or fra	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, farm, streetc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the beside the control of the basic and manner.	s of examination and/or in	th occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner as si ee and place, and due to	ated. the cause(s)				
To the To the comp	×	29b. Signature and title of certifier	(29c. License number	29	d. Date signed (Month,	Day, Year)				
		Deveniere Wrolle	034 m)	0006461	5	3/22/0	7				
		30. Name and address of person who completed cause of		1 .		() (MD				
	tate	31. Date filed (Month, Day, Year) 33. Regi	strar's Signature	5 Piccard D	r 20	ckyille	VVI)				
Regis		MAD 2 9 2007	as the Ann	all s							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Dav Year 20 2017 4c. County of Death SAUM MAR /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Vorth Wes Hirsare If Under 1 Year | If Under 24 Hrs Un 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days 1 M 2 □ F 317-34-604 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 PYes 2 No Director Himor WD 10e. Street and Number 10g. Citizen of What Country? 3403 91234 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 2 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Bivorced whit. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ransdox 17. Father's Name (First, Middle, Last) ∪ ೧K Be (18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) remoter 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 18434 any AM 1232 midually 23a. Part1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear lilure. List only one cause on each line. Immediate Caus. (Final disease or con lifton resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed STAGE signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an ate has bage 2 s autopsy this certificate 2 **X** No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient မှ 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Within 24 hours after occur.

To the Funeral Director: After 1 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHINDER P MEHTH

Registrar
DHMH 17 Rev 1/2001

State

monterel

Registrar's Signature

THLES

31. Date filed (Month, Day, Year)
MAR 2 9 2007

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			5	State	of Marylar	nd / Depa	artment of	Health ar	nd Mental	Hygien	e	
			1 - For State Registrar			Ce	rtificate o	f Death		Reg. N	2007	09999
- 195 300	Physici	an	1. Decedent's Name (First, Middle	e, Last)					2. Date Mon	of Death	ay Year	3. Time of Death
	/Medic		SHIRLEY M	•	SUBOR	ik_	1 41 67 7			NAR	Z7, 200	
	Examir	ner	4a. Facility Name (If not institution Howard County			1	Columb	or Location of D	Death		c. County of Dea Howard	ıın
Fı	uneral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Yea	r If Under 24		of Birth	9. Bir	thplace (State or Foreign
	rector		212-28-2628	1 □ M 2 🛣 F	76	Yrs.	Months Day	s Hours			931 Mar	yland
and	i t		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
Mary	ied a	to	MD Balt:	imore		Baltin	nore					1 □ Yes 2 □ No
th the	or 28a e notifi	Director	10e. Street and Number		3		10f. Zip Code			10g. C	itizen of What Co	ountry?
ath wi	23a		3207 N. Rolling	_			21244				ted Sta	
ier de	items ner n	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Marri	Armed F	cedent Ever in U orces? 2 X No	J.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin Jban, Mexican, F	n? (Specify Yes Puerto Rican, et	tc.)	14. Race - Ame Black, Whi	
036 urs af	aľ, or Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes G	ive		1 ☐ Yes 2 💢 N	o Specify:			Specify: W	nite
Maryland 21215-0036 to 2 should be filed within 72 hours af the and Mental Hygiene.	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed		t's Education st grade completed,)	(Give	dent's Usual Occ	e during most o	of working	16b.	Kind of Business	/Industry
within sie.		ldm	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT use reti Lal Sec.	•		Δ,,	ditor	
Ind 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene.	other ent, <u>t</u> l		17. Father's Name (First, Middle,	Last)		000	tar bee.	- 1	s Name (First, A			
rlan uld be Vental	rked tic ev	To Be	J. Harry Suboo	J. Harry Subock Fdith Pahl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town								
laryla 2 should I and Men	is ma rauma	ľ										Zip Code)
e, N 1 and Health	item 27 other to		Betty Sauter (s	sister)	20b.		Jean Dr osition (Name of matory or other p		more, M		4 Location - City or	Town, State
MOF Pages Tent of	t: if it y or o		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			cemetery, cre • Olive			31/2007		allstow	
Baltimore, permit. Pages 1 ar Department of Hea	Important: if it any injury or once.		21. Signature of Funeral Service			2:	2. Name and Add	lress of Facility				-
m aa	E E E		Joll 1	elle		Bu	ırrier-Q	ueen Fui	neral H	ome an	d Cremat	tory, P.A.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	th. Do not en	ter the mode of d	ying, such as ca	ardiae or respira	tory arrest,	ieid, m	Approximate Interval Between Onset and Death
Phys	sician edical		Immediate Cause (Final disease or condition resulting in death)	_a SE	PTIC S	SHOCK						4 DAYS
	miner				(or as a consec							4 DAYS
A D	#	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consec	quence of):		10.0				
60,745 be executed	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	U	Or as a consec		BACKE	REMIA				14 DAYS
760, My	nysician and he burial-transit	cal E			(01 40 4 0011000	abonico ciy.						
687 tificate	g phys as the			d								
. Box death cer	attending phy I for use as the	an/N	IF FEMALE: 23b. Was decedent pregnant		itcome pf pregn birth 2 ☐ Feta		∃Ectopic pregnar	ncy			23d. Date of de Month	livery Day Year
O. H	by the at tached fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of one	death 5	Other (specify)			_	WOTH	Day
that t	ed by detac		Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying cause o	jiven in Part I.	23e	. Did tobacco	use contribute to	o the cause of death?
Vital Records, sician: The law requires the	s been signed to should be dete	Completed by	MURBID OBES	ידץ					_	1 ☐ Yes	2 X No 3□P	robably 4 □Unknown
eco law re	as bee 2 sho	plet	ACUTE RENAL	FAILURE					24a.	. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	s certificate has t lirector, page 2 s	Com							1	performed? Yes 2 N	death?	·_
VIT3	certifi	Be	25. Was case referred to medica examiner?	Hospital:	· · · · · · · · · · · · · · · · · · ·	IED/Out-1		ther	f Death (Check			
P Phys	a ‡i): To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time o	IL SELDOA	4 L Nursi		Residence cribe how inju	6 □Other (Spe ury occurred	ecify)
DIVISION OF it or Attending Phy after death.	or: After ne funera	atio	1 ☑Natural 5 ☐ Pendin investig	gation	nth, Day Year)	Injury		Yes 2 No	>			
or Atte	lirect on by the	Certification:	3 ☐ Suicide 6 ☐ Could determ	ined 200. Place	e of injury - At h ling, etc. <i>(Sp</i> ec <i>i</i> i		eet, factory, offic	е		ition (Street a or Town, Sta		ural Route Number,
pitai o	illed i		29a. Certifier 1 Certifylr	ng Physician: To the	e best of my kno	owledge, deat	h occurred at the	time, date and	place, and due	to the cause(s) and manner a	s stated.
Division or Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.	To the Funerai Director: / completely filled in by the f	Medical		Examiner: On the I								
To th withir	Lo #	M	29b. Signature and title of certifie	11- 1	1-06		29c. Lice	nse number		29d. D	ate signed (Mon	th, Day, Year)
			11/	7,7	1049			63147		MA	R 27, Z	700
	10		30. Name and address of person JEFFREY BRIAN	. 1	se of death (Iter 5755		Print)	Colu	MBIA, N	10 2	1044	
	Sta	te	31. Date filed (Month, Day, Year)	2007	Registrar's Signa	ature /			Court to			
F	Registr	ar	MAK 2 9	2001	yes do	September 1	19-12-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 15AM MARCH Bruce E. Snyder 23 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Burnie altimore washington Hedical Frunde. 8. Date of Birth (Month, Day, Year) Apr 21, 19 Birthplace (State or Foreign Country) Age (In yrs. last birthday, If Under 24 Hrs. 1 M 2 □ F Yrs. 36 213-11-7409 1970 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □ Yes 2√□ No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 473 Mainview Court 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) accountant financial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Robert Snyder Sr Nancy Loretta Wetzel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janette Stower/sister 203 Lincoln Avenue SW Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

attending physician

law requires that the death certificate be executed

Hospital or Attending Physician:

within 24 hours after death. To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Snyder, Bruce

Examine burial-tran Physician/Medical the for use as After this certificate has been signed by the funeral director, page 2 should be detached Completed by Be Certification: To completely filled in by the

	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):		
· ·	ed		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy 5 Other (specify)	23d. Date of d Month	lelivery Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	
		autopsy prior to	autopsy findings available o completion of cause of ? es 2 □ No
25. Was case referred to medical examiner?		h (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Sp	pecify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Rural Route Number,	
29a. Certifier \ 1 Certifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and manner	as stated.

State Registrar

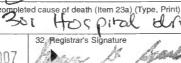
Medical

31. Date filed (Month, Day, Year) MAR 29

30. Name and address of person who

29b. Signature and fittle of certifier

(Check only



and manner stated.

BLAVE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Burnie MD

29d. Date signed (Month, Day, Year)